S
353.64
I3mcs
1980

MONTANA

COMMUNITY SUPPORT PROJECT

Year 03 Progress Report

August 31, 1980

MONTANA STATE LIBRARY
3 0864 1002 0527 0

MONTANA

COMMUNITY SUPPORT PROJECT

Year 03 Progress Report

August 31, 1980

STATE DOCUMENTS COLLECTION

JUN 0 6 2003

MONTANA STATE LIBRARY
1515 E. 6th AVE.
HELENA, MONTANA 59620

Digitized by the Internet Archive
in 2010 with funding from
Montana State Library

http://www.archive.org/details/montanacommunity1980drac

Year 03 Progress Report

For Period from 3/1/80 - 8/31/80

By David Drachman, Program Evaluator

Project Title

Demonstration and Replication Project
State/Local Community Support System (CSS)

Contractor

State of Montana
Department of Institutions
1539 11th Avenue
Helena, Montana 59601

Project Director

Philip Powers, State Coordinator
Community Support Project
Mental Health & Residential Services Division
1539 11th Avenue
Helena, Montana 59601
Telephone: (406) 449-3964

Contract Number

278-78-0011 (MH)

Date Submitted

August 31, 1980

MONTANA
COMMUNITY SUPPORT PROJECT

Year 03 Progress Report

Table of Contents

Page

A. Progress on R.F.P. Tasks and Outcomes

Task #1 ---------- 1
Task #2 ---------- 5
Task #3 ---------- 7
Task #4 ---------- 9
Task #5 ---------- 15
Task #6 ---------- 17
Task #7 ---------- 19
Task #8 ---------- 22
Task #9 ---------- 22
Task #10 ---------- 23

B. Special Reports and Documentation

1. Warm Springs State Hospital Agreement ---------- 25
2. S.S.I. Booklet ---------- 28
3. Rehabilitative Services Division Agreement ---------- 57
4. Training Module for Native American Paraprofessionals --------- 67
5. Retrospective Follow-up Study ---------- 85
6. Report on Recidivism at Warm Springs State Hospital ---------- 92
7. Longitudinal Follow-along Study Instrument ---------- 96
8. Component Assessment Instrument ---------- 104
9. Identification of chronically mentally ill ---------- 110
10. C.S.P. Implementation ---------- 118
11. Residential Care Continuum Study ---------- 122

C. Contextual Factors Affecting the Project ---------- 140

D. Administrative Information ---------- 142

E. Appendix

1. Resumes ---------- 145

Montana CSP Year 03 Progress Report

Introduction. This report covers the activities of Montana's Community Support Project from March 1, 1980 to August 31, 1980. Using the Management Plan as a framework, progress on each of the nine tasks will be described in a narrative section. Each narrative section will be followed by a chart summarizing the current status of each of the task's activities.

A. Progress on RFP Tasks and Outcomes

Task 1: Continue to implement and refine the local CSS demonstration.

Sub-task A: Make all ten CSP components systematically available.

A written agreement between the state hospital and region III regarding respective roles and responsibilities is nearing completion (see Section B page 25). A separate agreement regarding responsibilities for patients on extended home visits was delayed while the first agreement was focused upon. It is anticipated that this latter agreement will be finalized by October 1, 1980.

On the vocational front, one outside contract for the janitorial crew has been secured and two more are currently being negotiated. Since the beginning of the contract period, the Community Placement coordinator has succeeded in placing ten clients in either sheltered or competitive positions. This coordinator has also begun working with sheltered workshop personnel on attempting to subscribe local employers to the placement service. A major hindrance to this effort's success is the fact that there are over 70 other job placement workers, from various agencies, in the Billings area who are attempting to obtain the same commitments from these employers.

So far 22 volunteer case managers have been trained under the Action Grant

awarded to Region III. A second group will commence training on September 1, 1980. The new co-ed cooperative apartment is now being supervised only one hour per week, as called for in the Management Plan.

Region III staff have begun an effort to consult with all of the Region's district judges regarding CMHC pre-screening of clients bound for the state hospital. The district judge of Yellowstone County (the region's most populous) has been consulted with, and the other judges will also be contacted.

	Activity	Due Date	Performance Indicator	Current Status
1)	Establish written agreement between state hospital and Region III regarding responsibility for extended home visit patients	5/1/80	Written agreement completed	Due date reschedules to 9/1/80
2)	Gradually convert new cooperative apartment into a self-governing facility	2/28/81	Facility supervised 1 hour per week or less	Facility is now supervised 1 hour per week
3)	Secure outside contracts for janitorial work crew	2/28/81	2 contracts secured	1 contract secured, 2 more being negotiated
4)	Match CSP clients to jobs by means of the Community Placement Service	2/28/81	20 clients matched to jobs	10 clients placed
5)	Involve community employers in the Community Placement Service on an ongoing basis	2/28/81	5 employers regularly using the service	no employers yet subscribed
6)	Continue fortnightly case staffings	2/28/81	All CSP clients staffed	All CSP clients are being staffed
7)	Consult with Region III district judges on CMHC pre-screening for state hospital	6/1/80	10 consultations made with district judges	one consultation completed (Yellowstone County)
8)	Train volunteers as case managers and assign to clients	2/28/71	40 volunteers trained and assigned	22 volunteers trained more training scheduled for 9/80

Activity	Due Date	Performance Indicator	Current Status
9) Design multimedia educational package to increase other agencies' awareness/acceptance of CSP clients	6/1/80	10 agencies viewing the presentation	THIS ACTIVITY MOVED TO SUB-TASK C, ACTIVITY 4

Sub-task B: Assure CSP responsiveness to ethnic minorities.

Psychiatric commitment of reservation Indians has not been challenged in Montana, although its legal status remains unclear. Indian Health Service has taken the lead in surveying the various involved federal, state and local agencies and reservations to obtain needs and resources. Further work is needed to clarify priorities. A plan to train the M.U.I.A. paraprofessional counselors in dealing with the chronically mentally ill was suspended when it was learned that these individuals constitute an extremely small proportion of their caseloads. However, some training on general mental health problems has been conducted.

A working agreement between IHS and Region III has been postponed for the time being. Region III staff, based on past experience, feel that it is more prudent to allow the current strong informal relationship to "grow" a little more before attempting to formalize it.

On August 9, 1980, the program evaluator met with the "Hispanic Task Force" in Billings. This task force was created by the 1979 state legislature to survey the needs of this rapidly-growing segment of Montana's population. This survey did not contain a mental health component, but the Task Force members have lent their support to a separate mental health survey to be designed by the program evaluator in conjunction with them. The survey results will be supplemented by date from Region III's MIS.

Activity	Due Date	Performance Indicator	Current Status
1) Clarify the legal issues surrounding the commitment of reservation Native Americans	6/1/80	A clear list of rules for handling the legal side of Native American commitments	Due date moved to 12/31/80
2) Train M.U.I.A. paraprofessionals in handling of severely mentally ill	4/1/80	3 training sessions focused on severely mentally ill	One training session completed. Need being reassessed.
3) Develop working agreement between IHS and CMHC regarding processing of mentally ill Native Americans	5/1/80	Written agreement completed	Due date moved to 11/15/80
4) Gather statistics on Region III Hispanic population	5/1/80	Written report completed	Due date moved to 10/31/80
5) Conduct mental health needs/resource survey of Region III Hispanics	6/1/80	Written report of survey results	Due date moved to 10/31/80

Sub-task C: Involve advocacy groups.

Attempts to involve Montana's MHA in a state-level attempt to develop consumer advocacy have not been successful. However, the response at the local level has been gratifying. Local MHA chapter heads have been recruited to help develop consumer advocacy in Region III and both Region III & IV's MHAs also sponsor very active socialization clubs which serves as a forum for the clients consumer concerns. The Billings MHA will co-sponsor a workshop on consumer issues with the CSP during the fall.

The statewide CSP has contracted with an advertising agency to develop a slide presentation, some brief TV spots and an annual report which will present a "clients eye" view to professionals and the interested public. These media programs, originally scheduled to be complete by 5/1/80, are just now being completed and should be ready by September 30, 1980.

"Back Wards to Back Streets", a nationally produced P.B.S. film featured Region III's C.S.P. efforts.

Activity	Due Date	Performance Indicator	Current Status
1) Establish MHA sub-committee for the chronically mentally ill	5/1/80	Subcommittee meets 4 times during contract year	Committee not established
2) Establish a statewide consumer organization	7/1/80	Organization formalized and incorporated as a non-profit corporation	No statewide organization; several local parent groups are active in consumer affairs
3) Involve local consumers and consumer relatives in national advocacy meetings	Ongoing	20 consumers or relatives involved in advocacy meetings during contract year	Several consumers &/or relatives will attend regional LCC in Yakima, 10/80
4) Develop multimedia presentation for interested citizens and mental health personnel	5/1/80	12 presentations during contract year	Due date moved to 9/30/80
5) Develop TV programs to increase awareness of general public	5/1/80	Programs aired twice during contract year	1st showing on PBS of Back Roads to Back Streets on 5/1/80. Due date moved to 8/24/80 for 2nd showing with local commentary.

Task 2: Continue to identify issues with implications for State-level activities

Rural CSS development remains a major issue for Montana's CSP staff. In mental health regions containing a large city, such as Region III, it is possible to refer clients needing extensive services (such as daycare or group homes) to that city where enough funding and staff are available to provide those services. In Region I, no such large city exists, and the three principal towns (Glasgow, Glendive, and Miles City) must be utilized as effectively as possible to provide needed services. Region I is unique among the five regions in having no large city to use as a CSS "base". In spite of this, some rather extensive services are being offered at the three principal satellites, and the techniques used to develop these services should prove useful in developing the rural areas of the other regions.

Region I is also unique in the management model used by its CSP staff. In other regions, the aftercare program head supervises all CSP staff, including those

located in the satellite offices. In Region I, each CSP staffer is supervised by the head of his or her satellite office, with the aftercare program head having only advisory input. This arrangement is advantageous in that it mirrors the high degree of autonomy that each satellite office must maintain in the sparsely populated region. However, a disadvantage is that the frequent communication that would be necessitated by line authority over the three CSP staffers is not required and may result in isolation and a weakening of their efforts.

During the first six months of the third contract year, collaboration between CSP and the Manpower Development Project has been substantial. The two projects have jointly sponsored staff visits between the CMHCs and between the CMHCs and Warm Springs State Hospital, for purposes of exchanging information regarding programs and treatment planning for the chronically mentally ill. The two projects have also finalized plans for a state-wide workshop on partial hospitalization, which is intended to serve as a forum at which daycare workers can exchange ideas and problems. Planning has also commenced on a jointly sponsored workshop on consumer advocacy. The evaluators of the two projects have begun work on an NIMH small grant application to research sexual and ethnic biases in the diagnostic process.

For the third year in a row, Montana's HUD section 202 application has been rejected. This rejection has underscored our need to be more effective in utilizing the state's Governor's Office and Congressional Delegation in obtaining this type of funding. After this last rejection (in March, 1980) a concerted effort was made to find out what was lacking from the application. As a result of this feedback, a comprehensive cost study of CSP will be conducted in the five centers in order to document Montana's extensive commitment of state funding to the chronically mentally ill. In our next HUD application this information will be presented, and accompanied by the active promotion, rather than simple endorsement of the state's

political leaders.

Activity	Due Date	Performance Indicator	Current Status
1) Monitor the results of various strategies for rural application	2/1/80	Written discussion of pros cons of various rural strategies	Written discussion contained in this report
2) Determine advantages and disadvantages of Region I and Region III management models	2/1/80	Written discussion of pros cons of various management models	Written discussion contained in this report
3) Continue to identify issues on which CSP and MDP should collaborate	6/1/80	9 new issues identified	4 new issues identified so far
4) Make more effective use of legislative and Governor's Office in fund seeking efforts	2/28/81	3 lobbying attempts made	Date collection started, for use in conjunction with concerted lobbying effort to accompany next year's HUD application

Task 3: Continue to develop and implement methods for state-level interagency collaboration and policy modifications.

Progress on this task has been slow, as CSP staff have found reluctance on the part of many agencies to involve themselves with the chronically mentally ill. The CSP advisory committee continues to meet, and provides a good source of contacts and leads for joint funding efforts, but these contacts have led to few results beyond verbal endorsement of our efforts. Initial contacts have been made with DCA regarding DOT section 18 transportation money for our clients, and with OSPI regarding vocational training money, but no funds have been committed as yet. Plans to support group homes with 314(D) money have ended with the demise of that funding source.

Chronically mentally ill group homes are now eligible for good stamps and the State Department of Social and Rehabilitative Services has begun to implement this.

Steps are now being taken by the Mental Health Division to communicate this ruling to all relevant state, local and federal agencies, so that this funding effort can move forward.

The bright note under Task 3 has been in the area of seeking Mental Health Association cooperation in forming a consumer organization. Several MHA members have volunteered to develop such groups in their local areas. In the Billings area, MHA support has been obtained for a consumer workshop. Additionally, the MHA sponsors social clubs for clients in several areas, which serve as a forum for their members' consumer interests.

A recent manual re-written by the state-level coordinator from the Georgia model should be of assistance in helping case managers obtain social security benefits for their clients. This manual, which presents a lengthy description of SSI and SSDI benefits, and how to apply for them, has been distributed to all five centers (see page 28 , section B).

A recent co-operative agreement between the Mental Health & Residential Services Division of the Department of Institutions and the Rehabilitative Services Division of the Department of Social and Rehabilitation Services has improved the inter-relationships between these two state agencies (see page 57, section B).

Activity	Due Date	Performance Indicator	Current Status
1) Continue to convene the CSP advisory committee	2/28/81	80% average attendance at meetings	75% have attended last 2 meetings
2) Work with DCA in securing DOT section 18 funding for chronically mentally ill	6/1/80	15 clients utilizing DOT support	No funding secured as of 9/1/80
3) Seek vocational training money from OSPI	6/1/80	5 clients receiving OSPI funds	No funding secured as of 9/1/80
4) Secure 314(D) money for group home funding	7/1/80	8 group homes receiving 314(D) funds	Funding source no longer exists
5) Secure food stamps for group home commodities	2/28/81	12 group homes utilizing food stamps	Funding slowed pendi rules clarification

Activity	Due Date	Performance Indicator	Current Status
6) Represent concerns of the chronic client to the Long-Term Care Committee.	2/28/81	2 meetings attended by statewide coordinator	Committee has completed needs assessment & now moves into active state planning. 2 meetings attended.
7) Seek MHA assistance in forming a consumer organization	4/1/80	Written working agreement between CSP and MHA	No written agreement, however cooperation has been obtained from some local chapters
NEW ACTIVITY			
8) Develop cooperative relationship with Rehabilitative Services Division	8/31/80	Formal working agreement signed	Agreement signed

Task 4; Continue to develop, refine, and implement the statewide program development strategy.

Sub-task A: Utilize Region III experiences in program development

Our experiences with rural development in Region III have made it clear that a full range of CSS components cannot be implemented in the more rural areas. Therefore it was decided to negotiate with each region, as it entered CSP, which of the ten CSS components would be emphasized in the state-region CSP subcontract. This process resulted in six components being emphasized in Region I. It was decided to emphasize all ten components in Region II, having as it does one of the more highly developed community support systems. Negotiations with Region V will be completed by September 1, 1980.

An important aid to determining component strengths and weaknesses in each of the regions is the Component Assessment Instrument, a recently developed device for measuring implementation of the ten components in an objective manner. The instrument was administered in Region III during April, 1980 and in Region II during July, 1980. Assessments of the other three regions are scheduled for later this year. The data produced by these assessments will prove useful in monitoring contract compliance, and, in the case of Region IV, will provide a basis for contract negotiations.

A CSP analysis conducted in Region III last year should prove useful in justifying and promoting the CSP to funding sources such as state legislators and county commissioners. This analysis indicated that it is cheaper to maintain the chronically mentally ill client in the community than in the state psychiatric hospital, even when the cost to all involved community agencies (not just the CMHC) is considered. It is expected that these data will be presented during the next legislative session (January 1 to April 30, 1981) and at meetings of the Interim Finance Committee to take place afterward.

At this writing, progress in Region V can be reported on replication of Region III's volunteer case manager program. The project has functioned smoothly so far in Region III, and no major obstacles for foreseen to attempting similar efforts in other regions expressing an interest. Staff from two of the other regions have site-visited Region III's volunteer program in order to learn about implementation.

The initial meeting between the state hospital liaison, CMHC staff and Crow Reservation Indian Health Service staff has established frequent, ongoing communications among all three parties regarding the chronically mentally ill Native American. Staff in Regions II and V are planning similar meetings with IHS staff on those reservations.

Activity	Due Date	Performance Indicator	Current Status
1) Negotiate which components should be stressed with CMHC directors	2/29/80 Region II	"Earmarking" of components in CSP contract	All 10 components stressed in this contract
2) Use evaluation data to determine component strengths and weaknesses in Regions, I, II, III, V	6/1/80 Regions I & II 9/1/80 Regions II & V	75% scores for targeted components on component assessment instrument	59% scores, on average, in Region III. Region II data collected but not tabulated
3) Use cost data to justify project to funding sources	As needed	3 presentations to legislators and other funding sources	No presentations needed as of 9/1/80

Activity	Due Date	Performance Indicator	Current Status
4) Adapt volunteer training methods to Regions I, II, V	1/1/81	Volunteer implementation plan for each region	Plan for Region V written as of 9/1/80
5) Develop state hospital - reservation linkages in Regions II, V	2/28/81	4 meetings between State Hospital and reservation staff	No meetings as of 9/1/80

Sub-task B: Continue CSS implementation in Region I.

Assessment of CSS implementation in Region I is behind schedule. So far Regions II and III have been assessed, and the assessment of Region V has been scheduled for the last week of August, 1980. Assessments of Regions I and IV have been re-scheduled for October, 1980.

With regard to the region's Native Americans, a concerted outreach effort is now underway. There are paraprofessional Native American outreach workers in place on the Northern Cheyenne and Fort Peck reservations, and contracts concerning out-reach have been secured with the reservation tribal health boards as well as the Montana United Indian Alliance office in Miles City (M.U.I.A. is an organization of off-reservation Indians).

Region I CMHC has participated in numerous inter-agency meetings in recent months. The principal agencies participating have been police, welfare, vocational rehab-ilitation and sheltered workshop, which are attending in order to establish on-going communication links and discuss problem areas. In Glasgow an ongoing inter-agency "Adult Service Team" has grown out of such meetings. Regular informal contacts are also maintained with the area's nursing homes, and attempts are underway to formalize these with written contracts. An agreement with WSSH re-garding respective responsibilities is completed.

Daytreatment programs are continuing at Miles City, Glendive and Glasgow, with a

total enrollment of approximately 45 different individuals. A major use of CSP funding has been to purchase medication for CSP clients not able to obtain reimbursement and in many cases this has averted rehospitalization (which is the only other way for these people to obtain medication without expense). An additional focus of Region I's CSP efforts has been the aggressive outreach to parents and relatives of chronically mentally ill clients.

Region I's aftercare staff have not recently attended any external staff development functions, but will be attending the upcoming workshops on partial care and consumer affairs, as well as the regional Learning Community Conference.

Activity	Due Date	Performance Indicator	Current Status
1) Assess implementation of the six targeted components	6/1/80	75% scores on component assessment instrument	Assessment rescheduled for 10/80
2) Establish a Native American outreach worker on the Fort Peck reservation	10/1/80	Contract for services of 1 Native American outreach worker	2 outreach workers in place
3) Meet with other community agencies to coordinate services to CSP clients	7/1/80	Ongoing contracts with 5 agencies	Strong informal linkages established
4) Augment day treatment programs	7/1/80	40 clients enrolled in day treatment programs	45 clients currently enrolled
5) Establish a liaison to the state hospital at Northern Cheyenne & Fort Peck reservations	9/1/80	Formal designation of liaison persons	Outreach workers designated as liaisons
6) Ensure attendance of Region I CSP staff at appropriate staff development activities	2/28/81	Three CSP staff attending one or more conferences, workshops, etc.	Attendance at 2 workshops and regional LCC has been planned

Sub-task C: Plan and initiate program development in Region II

The process of identifying the chronically mentally ill has been completed in

Region II. This Region entered the CSP on March 1, 1980, and a written contract, emphasizing all ten CSS components, was finalized at that time.

Activity	Due Date	Performance Indicator	Current Status
1) Identify Region II's CSP population	2/1/80	100% of aftercare clients screened with CSP criteria	Completed and all clients are being screened at intake
2) Negotiate component services to be targeted	2/29/80	"Earmarking" of components in CSP contract	All ten components stressed in contract
3) Draw up contract emphasizing targeted components & assigning staff duties	2/29/80	Formalized contract	Contract written & signed

Sub-task D: Plan and initiate program development in Region V.

The chronically mentally ill on Region V's caseload have been identified, and an ongoing screening mechanism is in place. Negotiations are completed as to which components will be targeted in the contract, and how staff will be utilized. Plans have been made to orient daycare activities towards vocational skill-building, develop increased residential facilities and expand volunteer services.

Sub-Task D: Plan and initiate program development in Region V

The same series of efforts outlined above in sub-task C will be implemented for Region V during August, 1980.

Activity	Due Date	Performance Indicator	Current Status
1) Finish identification of Region V's CSP population	8/1/80	100% of aftercare clients screened with CSP criteria	All clients have been screened
2) Negotiate component services to be targeted	8/30/80	"Earmarking" of components in CSP contract	Contract negotiated (8/80)
3) Draw up contract emphasizing targeted components and assigning staff duties	8/30/80	Formalized contract	Contract negotiated (8/80)

Sub task E: Identify funding sources

As discussed earlier under Task 3, progress in securing outside funding has been slow. The HUD section 202 application for 1980 was submitted and turned down. A concerted effort to be successful the next time will be launched during December, 1980, involving Montana lawmakers and more extensive documentation of our current efforts.

Attempts to secure DOT section 18 funding, in collaboration with DCA, have not been successful as yet. Attempts to secure group home funding from FHA are behind schedule, and 314(D) monies are no longer available. Support of group home commodities with food stamps has been delayed pending a ruling clarification. The statewide coordinator continues to look for new funding opportunities and publicizes them to the mental health centers.

	Activity	Due Date	Performance Indicator	Current Status
1)	Resubmit HUD Section 202 application for demonstration housing for chronically mentally ill	1/15/80	Receipt of HUD response to application	Application submitted and rejected (3/1980)
2)	Secure assistance from Governor's Office & Montana representatives in lobbying for HUD Section 202 funds	1/15/81	1 meeting each with legislators, Governor's Office	Meetings planned for 11/80
3)	With DCA, attempt to secure DOT Section 18 funds for transporta- of chronically mentally ill	7/1/80	Submission of Section 18 application	Application not submitted, due date moved to 11/30/80
4)	Approach OSPI regarding vocational training funds for Region III CSP clients	5/1/80	Meeting with OSPI staff	This activity is located under Task 3, Activity
5)	Apply to FHA for group home funding	9/1/80	Submission of FHA application	Application not submitted, due da moved to 11/30/80

Activity	Due Date	Performance Indicator	Current Status
6) Secure 314(D) monies for group home establishment	7/1/80	Division approval of 314(D) allocation	Funds no longer available
7) Secure food stamps for group home commodities	2/28/81	30% of eligible group home residents receiving food stamp assistance	Funding awaits clarification of ruling
8) Continue to seek out new funding opportunities and alert appropriate agencies and CMHC staff to these opportunities	2/28/81	Number of new funding sources identified	3 new sources identified

Task 5: Continue implementation of CSP-Manpower Collaborative Action Plan

CSP-Manpower cooperation has continued on a number of fronts during the present contract year. A technical assistance proposal for inservice training at the Center for the Aged has been submitted to the NIMH regional office in Denver. Warm Springs State Hospital staff will assist in conducting this training. Training has also been made available to M.U.I.A.'s Native American paraprofessionals, in the form of an inservice training session using a specially designed training module (see section B, page 67). A statewide partial care workshop has been planned for November, with the purpose, in addition to providing a forum for exchanging ideas, of establishing a permanent statewide organization devoted to partial care concerns.

Manpower and CSP have jointly funded CMHC-CMHC and CMHC-Warm Springs staff exchanges which have become a principal means of discussing ideas and problems related to the chronically mentally ill. Another major step forward in building the capacity of Montana's mental health manpower has been the completion of a contract with the University of Montana for the placement of clinical psychology interns in rural CMHCs. So far, three interns have been placed.

As stated previously, a statewide MHA-backed consumer advocacy committee has not

materialized. However, cooperation at the local chapter level has been good. Volunteer case management programs have been implemented in Region V, and several centers have expressed an interest. Manpower and CSP will assist when appropriate.

Finally, the two project evaluators are jointly authoring an NIMH small grant proposal to study racial and sexual biases in the diagnostic process.

Activity	Due Date	Performance Indicator	Current Status
1) Formulate state hospital-CSP-MDP agreement regarding in-service training at Center for the Aged	4/1/80	Written agreement completed and signed	TA proposal submitted to Region VIII office
2) Develop training module about mental illness for Native American paraprofessionals	4/1/80	Module completed and distributed	Module completed and distributed
3) Form consumer advocacy sub-section of the MHA	5/1/80	4 meetings of subcommittee during contract year	Local chapter cooperation has been secured
4) Organize & convene a statewide conference for partial hospitalization staff	6/1/80	Conference held	Conference scheduled for 11/80
5) Initiate a program of placing clinical psychology interns into rural Montana CMHCs	10/1/80	5 interns placed	3 interns placed
6) Implement Region III's program for volunteer case managers in other CSP regions	1/28/81	At least 10 volunteers hired in each region	Region V is currently using volunteers
NEW ACTIVITY			
7) Fund center-center and center-WSSH staff visits	Ongoing	At least one staff visit per region during contract year	All regions have visited WSSH at least once
8) Apply for NIMH small grant award	11/1/80	Grant approved	

Task 6: Continue to identify and address CSP minority concerns.

Sub-task A: Gather data on Hispanics, Indochinese and Native Americans who are chronically mentally ill.

The majority of Indochinese immigrants to Montana have settled in Region V. Consequently, a contract was given to Region V to assess the needs of the Indochinese in the area. A written report on their needs has just been submitted, and will be followed up in September, 1980 with some CMHC MIS data pertaining to Indochinese clients. These data are being collected with the assistance of a Missoula-based Indochinese refugee organization.

On August 9, 1980, the program evaluator met in Billings with a legislature-appointed Hispanic Task Force to discuss plans for a mental health survey of Montana's Hispanic population. A methodology for the survey was developed, and the survey was scheduled to be administered during October, 1980. Data related to Hispanic CMHC clients are currently being collected from Region III's MIS.

Collection of data on Native American mental health needs has not yet begun. Tentative plans are to collect MIS data from the five regions during November, 1980.

Activity	Due Date	Performance Indicator	Current Status
1) Obtain archival data on mental health problems of Indochinese	6/1/80	Written report	Report rescheduled for 9/30/80
2) Obtain archival data on mental health problems of Hispanics	6/1/80	Written report	Report rescheduled for 10/1/80
3) Obtain archival data on mental health problems of Native Americans	6/1/80	Written report	Report scheduled for 11/30/80
4) Interview key informants regarding Indochinese needs/resources regarding mental illness	6/1/80	Written report of interview results	Report submitted on 8/4/80

Activity	Due Date	Performance Indicator	Current Status
5) Interview key informants regarding Hispanic needs/resources regarding mental illness	6/1/80	Written report of interview results	General public will be interviewed instead: scheduled for 10/31/80
6) Interview key informants regarding Native American needs/resources regarding mental illness	6/1/80	Written report of interview results	Postponed pendin results of MIS data collection

Sub-task B: Identify special service needs of Indochinese, Hispanics, and Native Americans

Identification of the special service needs of Montana's three principal ethnic minority groups has been delayed, pending the completion of the data-gathering activities discussed under sub-task A. The active communication links recently established with the Crow Reservation have given CSP staff an initial grasp of the special problems of this group.

Activity	Due Date	Performance Indicator	Current Status
1) Identify special service needs of Indochinese	7/1/80	3 special needs identified	Rescheduled to 1/1/81
2) Identify special service needs of Hispanics	7/1/80	3 special needs identified	Rescheduled to 1/1/81
3) Identify special service needs of Native Americans	7/1/80	3 special needs identified	Rescheduled to 1/1/81

Sub-task C: Encourage ethnic minority participation in state/regional CSS activitie

In conjunction with the Indochinese survey project, the assistance of three Hmong and one Vietnamese consultant was utilized. The Hispanic survey will be conducted by the program evaluator with the close consultation of a Hispanic aide, who has not

yet been chosen. These consultants will be re-contacted at a later date to obtain information about any key special interest groups who may be influential in reaching out to their fellow ethnic minority members.

To date there are two Native American outreach workers in place: one on the Fort Peck reservation and one on the Northern Cheyenne reservation. It is still planned to designate outreach workers on the other five reservations, but it has been decided to postpone these efforts until CSP is more firmly entrenched in Regions II and V (there are no reservations in Region IV). One reservation and one off-reservation mental health representatives have been added to the advisory committee.

Activity	Due Date	Performance Indicator	Current Status
1) Hire ethnic minority consultants	4/1/80	3 minority consultants hired	3 consultants hired, one more will be hired
2) Hire Native American outreach workers on reservations in as many regions as possible	10/1/80	7 Native American outreach workers hired	2 outreach workers hired, due date rescheduled to 2/28/81
3) Identify key special interest groups among ethnic minority population	7/1/80	4 special interest groups identified for each population	Rescheduled to 1/31/81
4) Obtain mental health data on ethnic minorities	6/1/80	Written reports for each minority group	Rescheduled to 1/31/81

Task 7: Continue CSS evaluation activities

Sub-task A: Continue documenting and evaluating outcomes of CSS efforts.

Evaluation task 1: Assess CSS impact on client movement to less restrictive environments.

During May and June, 1980, "retrospective follow-up" data were collected on all clients discharged from WSSH to Region III over a three-year period. The relationship of background characteristics, such as age, sex, and hospitalization history, as well as community support services received, such as residential living and

partial care, to rehospitalization were examined. Strong evidence was found for a preventive impact of community support services upon rehospitalization rates (a report of this study is on page 85 of section B).

Unfortunately retrospective searching of records did not permit the capture of all of the important aspects of community-based services. For this reason, an on-going longitudinal follow-along study is being designed. A special form will be devised to be administered to all CSP clients at three-month intervals (see section B, page 96). This form, adapted from one developed by the Iowa Mental Health Authority, contains scales for rating social skills, stress tolerance, independent living skills and an overall level-of-functioning scale, as well as a detailed checklist for describing the community support services the client is receiving. Each client will be monitored beginning with his entry into the CSP program, and clients who are rehospitalized at the time of an assessment will be assessed at the hospital facility. It is hoped that this monitoring system will be in place by 10/31/80.

Evaluation task 2: Finalize and implement the component assessment instrument (CAI).

The CAI was pretested in Billings during May, 1980, and found to be generally adequate for assessing CSS implementation. After alterations of a few indicators are made, reports will be written based upon data collected in Regions II and III and submitted to NIMH. Assessments will also be performed on the other three regions this fall. After these initial assessments, each center will be monitored on a yearly basis to check adherence to CSP goals and concepts. A list of the indicators which comprise the instrument, along with their sources, is included in section B, page 104.

Activity	Due Date	Performance Indicator	Current Status
1) Collect "follow-along" data on hospital clients discharged to Region III	5/1/80	Database created for ready access	Form designed, procedure will be implemented by (10/21/80) ("longitudinal follow-along study")
2) Assess impact of CSS elements on movement to less restrictive environment of active users and non users	6/1/80	Written report completed	Date collected, report included in section B ("retrospective follow-along study")
3)Finalize CAI and implement as needed	2/28/81	Implemented in all regions except IV	Instrument will be finalized during 9/80, data collected from regions II and III, other regions to be implemented during fall, 1980

Sub-task B: Furnish data to NIMH.

During the spring of 1980, the program evaluator assisted Macro-Systems in collecting data for the evaluability assessment, as well as assisting Market Facts in arranging collection of data with the Uniform Client Data Instrument in Region III.

Section B contains a number of evaluation reports based upon local data-collection efforts. One of the most important is a demographic analysis of the identified chronically mentally ill clients from all five center caseloads (page 110). This report also contains an addendum reporting the results of a chronically mentally ill identification study done at the state hospital. Two of the reports in section B have been published: a study of CSS implementation (page 118) and a study of client movement in the Region III residential continuum (page 122). Also contained in section B is a study of recidivism at Warm Springs (page 92), and the retrospective follow-up study mentioned earlier (page 85).

Activity	Due Date	Performance Indicator	Current Status
1) Assist NIMH in collecting national evaluation data	As needed	Data collection completed	Macro Systems and Market Facts staff assisted
2) Furnish reports on local efforts to NIMH	As completed	3 finished reports	5 finished reports in section

Task 8: Participate in CSP Learning Community Conference

A regional learning community conference has been scheduled for the northwestern CSP states in Yakima, Washington during October 1980, in lieu of the originally scheduled national conference. An attempt will be made, subject to monetary constraints, to send a Montana delegation to this conference which will be as representative of minority, consumer, CSP direct service staff, and state-level concerns as possible.

Activity	Due Date	Performance Indicators	Current Status
1) Attend learning community conference	Date(s) of conference(s)	At least three Montana representatives at conference(s)	

Task 9: Provide a progress report and year 04 program development plan to NIMH.

The progress report will be submitted on August 28, 1980, and has been written according to NIMH guidelines. The program development plan, also written according to NIMH guidelines, will be submitted on the same date.

Activity	Due Date	Performance Indicators	Current Status
1) Write and submit progress report	11/1/80	Report written & submitted	Report submitted on 8/28/80
2) Write and submit program development plan	11/1/80	Report written & submitted	Report submitted on 8/28/80

Task 10: Prepare final report.

The final report for year 03 will be submitted on 2/15/81, two weeks before the end of the contract period.

	Activity	Due Date	Performance Indicators	Current Status
1)	Prepare and submit final report	1/15/81	Report written and submitted	Submission date moved to 2/15/81

B. Special Reports and Documentation

Agreement between the

South Central Montana Regional Mental Health Center

and

Warm Springs State Hospital

(Task 1, Sub-task A)

AGREEMENT BETWEEN THE SOUTH CENTRAL MONTANA REGIONAL MENTAL HEALTH CENTER

AND

WARM SPRINGS STATE HOSPITAL

I. PREAMBLE:

The South Central Montana Regional Mental Health Center, hereafter referred to as Center, serves all of Region III, which consists of eleven counties: Big Horn, Carbon, Fergus, Judith Basin, Musselshell, Stillwater, Sweet Grass, Wheatland, and Yellowstone. Currently, Golden Valley County is a non-participating county. The program's central facility and administrative headquarters are located in Billings; however, there are satellite offices in Hardin, Red Lodge, Bridger, Lewistown, Roundup, Columbus, Big Timber, and Harlowton, as well as a second office (Neighborhood Counseling Center) in Billings. Since the Center's inception it has provided Aftercare Services to previously hospitalized individuals of Warm Springs State Hospital, hereafter referred to as WSSH. The Center has also provided Pre-care Services to clients prior to hospitalization or institutionalization and has attempted to provide screening and evaluation services to limit inappropriate admissions to WSSH. The Center has also attempted to maintain open communication with WSSH staff to facilitate comprehensive discharge plans.

II. TERMS OF AGREEMENT:

It is understood by the agencies endorsing this agreement that the

A. Mental Health Center:

1. has designated the Coordinator of Transitional Living Services as the Center liaison person to WSSH;

2. certain staff including the Coordinator of Transitional Living Services and Alternative Services Administrator will visit WSSH every two to three months to discuss Aftercare Services with WSSH patients, to evaluate patients for Center services, and to develop discharge plans with Warm Springs staff;

3. will maintain open communication with WSSH staff through weekly phone calls to the CSP WSSH liaison and every other month or two trip to WSSH;

4. will screen prospective WSSH patients from Region III in order to limit inappropriate admissions. This screening process is voluntary and is unable to screen all individuals sent to WSSH by private practitioners, physicians, courts and other voluntary admissions;

5. will notify WSSH prior to the patient's arrival. The Center will immediately send hospital records including lab and X-rays and other pertinent clinical information for Center patients sent from the Billings Deaconess Hospital (BDH); for admissions not sent from BDH, records will be sent as soon as a signed consent is obtained;

6. will review all referrals of Region III residents;

7. will review all out-of-region referrals and, when appropriate and with staff time available, develop discharge plans for Region III services with the exception of group home placements which must

be lower priority than Region III patients and when an opening exists must have method of payment;

8. will continue to provide appropriate inservice training at WSSH upon request and contingent upon the Center's availability and capability;

9. will invite WSSH staff to appropriate Center inservice presentations to further expand WSSH employees' training. Center staff will also orient WSSH personeel to Center services;

10. will collaborate in developing training and placement for displaced workers in the event reduction in WSSH census necessitates reduction in staff;

11. will accept outpatient follow-up for patients on home visits.

B. Warm Springs State Hospital:

1. will designate a liaison person for all discharge plans for Region III patients in WSSH;

2. the liaison person will visit the Center twice a year to facilitate better communication and become more familiar with Center programs;

3. will cooperate with Center liaison in developing WSSH discharge plans to include, but not restricted to, the following areas:
   a. living arrangements
   b. finances
   c. medical needs
   d. medication
   e. patient needs
   f. potential problematic behavior

4. will notify the Center prior to any patient's discharge;

5. will provide pertinent clinical information from the patient's WSSH files;

6. will invite Center staff to participate in educational or in-service presentations at WSSH;

7. will notify private psychiatrists or referring professionals that patient is being discharged and ask if they choose to be involved in the aftercare plans.

Bryce G. Hughett, M.D., Director
South Central Montana Regional
Mental Health Center

James E. Hamill, Superintendent
Warm Springs State Hospital

Mary J. Honaker, R.N.
Alternative Services Administrator

Ray Lappin, MSW, Director
Pre-Release Unit, WSSH

Valorie Everton, Coordinator
Transitional Living Services

Ron Weaver, Director
Intake Unit, WSSH

0;ead

Manual for Securing of SSI and SSDI Benefits

(Task 3)

? ?

EVERYTHING

YOU ALWAYS WANTED TO ASK ABOUT

THE SUPPLEMENTAL SECURITY INCOME
and
SOCIAL SECURITY DISABILITY INSURANCE PROGRAMS
of the
SOCIAL SECURITY ADMINISTRATION *

* But Were Afraid That Someone Would Tell You

? ?

Information About the Supplemental Security Income and Social Security Disability Insurance Programs of the Social Security Administration:

A GUIDE FOR MENTAL HEALTH STAFF

Prepared by:

Philip Powers, State Coordinator
Community Support Project
Division of Mental Health and
Residential Services
Montana State Department of Institutions

June, 1980

PREFACE

The following information has been compiled for those persons involved in assisting clients of the Mental Health Centers and Warm Springs State Hospital system apply for benefits under the Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) programs of the Social Security Act.

The material presented is instructional. It is not meant to be taken as Division of Mental Health and Residential Services policy. It is hoped that it will help to eliminate unnecessary delay between an individual's application for benefits and a final determination of eligibility or ineligibility for benefits under the SSI or SSDI programs.

A resource document that was essential in preparation of this booklet and from which many things were copied verbatim is the Social Security Handbook, sixth edition. It's available for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Stock number 017-070-00299-4.

CONTENTS

	Page
SUPPLEMENTAL SECURITY INCOME	1
Purpose, Source and Administration	1
Your Relationship to the Process	1
___Steps in the SSI Application and Determination Process	1
___Consultative Examination	3
___Information Needed from Your Facility by the Disability Determination Services	3
___Information Needed from Your Client at the Time of Application	4-5
Pre-Discharge Processing	6
The Monthly Payment	7
Representative Payees	8-9
Redeterminations	9-10
Denials	10
Additional Relationships to Vocational Rehabilitation	10-11
___Referral for Services	10
___Self-Support Plans	11
___SSI Payments to Inpatients	12
Relationship to Emergency Benefits	13
Relationship to the Veteran's Administration	13
Relationship to the Supportive Living Program	14
Relationship to Food Stamps	15
The Targeted Jobs Tax Credit Program	15
SOCIAL SECURITY DISABILITY INSURANCE	16
Purpose, Source and Administration	16
Criteria for Eligibility	16-17
Application Process	17

The Payment Process ---------- 17

Relationship to Vocational Rehabilitation ---------- 18

Relationship to Medicaid ---------- 18

Relationship to Medicare ---------- 18

CONCLUSION ---------- 19

Purpose, Source and Administration

Supplemental Security Income is the first federally administered cash assistance program in this country available to the general public. It is funded under the Social Security Act and is designed to provide a source of income for the aged, blind or disabled who have little other income or resources. The SSI program is funded from general tax revenues, unlike most other benefit payment programs funded under the Social Security Act which are paid from employers' and employees' contributions to the Social Security Trust Fund.

At the state level, the Social Security Administration contracts with a unit of state govenment, the Disability Determination Bureau (DDB) of the state Rehabilitative Services Division of the Department of Social and Rehabilitation Services, to determine applicant eligibility for SSI based on medical disability. Local offices of the Social Security Administration determine applicant eligibility based on non-disability factors (e.g., income, resources, living arrangement, age, citizenship, etc.)

Your Relationship to the Process

Your role is twofold, that of directly assisting your client and that of facilitating the submission of information to the DDB in Helena. Your relationship with your client is an individual thing, but there are certain things you can always do to facilitate information flow. To explain, a review of the steps in the application and determination process is in order:

1) An informed decision is made that your client should file a claim for SSI.

2)A. Your client goes to your local Social Security Office where he or she is interviewed by one or two claims representatives and interviewed extensively on matters related to birthdate and place, citizenship, living arrangement, marital status, income, financial resources, disability, work experience, and daily activities. (Your client should hope to be interviewed extensively and should be prepared to respond, since the more complete the documentation by the claims representative the less the DDB will have to depend on other sources of information to make the determination.) Your client's responses are the content of the application, which is signed by your client and kept on file in the local Social Security Office, and the Disability Report which is sent to the DDB.

B. Your client or someone acting on your client's behalf -- you, other staff of your program or facility, a family member, home provider or other interested person -- may telephone your local Social Security Office to file a claim. Many times, particularly in larger cities where there is one phone number for all offices, the person answering the call will take down the name and phone number of the person filing the claim and have a claims representative call back. Then the claims representative calls back and conducts the interview by phone. Technically, the Social Security Administration (SSA) is supposed to conduct face-to-face interviews to avoid fraudulent claims and,

even when the interview is conducted by phone, they may ask that the applicant appear at the Social Security Office to sign the claim. However, if the claims representative has good reason to believe the claim is legitimate and that the claimant would be greatly inconvenienced or disturbed by a trip in to the Social Security Office, the claims representative will send the completed claim to the claimant (or to the person acting on behalf of the claimant). If there are questions that the claims representative is unable to get answered over the phone, the claim may arrive with big check marks beside an item or two that will need to be completed before the claim is signed by your client and returned to the Social Security Office. (The claimant must sign the form unless he or she has been declared legally incompetent.) There will also be a list of "proofs" required which may include proof of age, proof of income and so forth. In addition, there should be a release of information form for each facility at which the claimant received medical treatment and for each examining physician.

Any time the SSA accepts a claim by some third party on behalf of the claimant they may ask that the person making the claim be the person most feasible to act on the claimant's behalf. So, should you seek to file a claim on your client's behalf, you may be asked to arrange the telephone interview with the person closest to your client or the person most likely to have your client's financial best interest at heart. This doesn't mean the SSA won't take the claim from you if you're the most appropriate person to act in your client's behalf. It only means you may have to respond to the issue of appropriateness.

Information requested about the claimant is the same as in 2 A on the previous page.

3) If it appears your client is eligible based on income and resources, the claims representative sends the Disability Report, along with release forms, all signed by your client, to the DDB. The claims representative should send a release form for each facility at which your client indicates treatment was received and for each examining physician.

4) The DDB receives the Disability Report, starts a file for your client and sends letters to each of the facilities for which a release was received, requesting medical evidence of record and any other objective information about the mental status of your client which may be of assistance in determining the extent of your client's disability. Note that they are not asking just for a diagnosis and history of treatment or the results of psychological testing. They want objective information about the degree to which your client's disability interfers with his or her ability to function normally.

5) The DDB waits for the requested information to come in from the facilities. At any time that it is felt sufficient information is in to make an accurate determination, the determination is made and the client is notified of his or her eligibility status. When two or three weeks elapse and the information which has been sent is too sketchy or not enough facilities have responded, the DDB makes an attempt to contact the facilities which have not responded or to encourage more comprehensive information from those facilities that have responded. Of course, each additional contact to get the necessary information extends the time it takes to reach a disability determination.

Sometimes it appears that all the available information is in, but it still isn't sufficient for a determination. In those cases, the DDB will schedule and pay for an examination of the claimant by a psychiatrist or psychologist. The client is scheduled with a psychiatrist or psychologist from a list of approved SSR consultants and is sent a notice of the appointment time and place. It is imperative that your client keep this appointment or have it rescheduled. Scheduling is done through the DDB in Helena, so rescheduling must also be done through the DDB. The phone number will be listed on the appointment letter your client receives from the DDB. They will accept collect calls from persons who need to reschedule and who can't afford to place the call. Failure to keep the appointment can only result in a delayed determination and may even result in a denial of the claim. The DDB is sometimes criticized because the appointments made for the applicants are often not conveniently located or timed. The DDB is required, however, to use a physician or psychologist who has an agreement with SSR to perform these consultative examinations and they try to use consultants from whom they've had good experience in getting prompt reports on the examination. In addition, the DDB will reimburse your client for travel expenses.

NOW, WHAT IS YOUR ROLE IN THIS INFORMATION GATHERING PROCESS? Well, for one thing, you can educate the staff in your facility about the kinds of information the DDB is really looking for in their attempt to make a determination. A diagnosis, even when combined with a prognosis, is not enough. The staff at the DDB have their "quality assurance" checks too and auditors whose business it is to make sure the DDB isn't giving away federal tax money. What they need is evidence to document your client's claim that he or she is so severely disabled that "substantial gainful activity" is not possible and, moreover, that this disability is expected to last more than a year or result in death.

What the DDB wants, then, are not only copies of medical evidence of record, but any objective statement of facts you or any other staff person in your facility can make which will assist the DDB in estimating the level of dysfunction. Such statements do not have to be reviewed and signed by a physician or clinical psychologist unless it is the policy of your facility to do so. The DDB is glad to have objective statements by the staff person most familiar with the client regardless of educational credentials. A form is attached as Appendix A which is used by some facilities to supplement medical evidence of record. DDB staff indicate that complete responses to the four questions on Appendix A, combined with significant medical evidence of record, would probably provide all the information they need from a given treatment facility. You may wish to use that form or a similar form of your own design to provide objective statements of fact. However, do not limit your response to these guidelines if you have additional statements of fact to make which will assist the DDB in determining the severity of your client's disability. Medical evidence of record can be copied and initialed by any person in your facility with permission to do so. Medical evidence of record should be initialed or stamped in some way so as to indicate that the copy is official, but it, like any other statement about the client, need not be initialed by a physician or clinical psychologist unless it is the policy of your facility to do so. (Please note: Opinion statements such as "In my professional judgement this client is too disabled to work" or "It is my opinion that John Doe is too dysfunctional to be economically self-sufficient" are not recognized as evidence and will not be used in the disability determination process. However, objective statements such as "Case notes by day treatment staff indicate continued inappropriate behavior..." or "Client is disoriented to time and space" are objective statements of fact but must be supported by examples and will be considered in determining the disability.)

In addition, you can prepare your client to apply for SSI by helping the client secure the information he or she will be required to supply to the claims representative at the Social Security Office and by encouraging honest and complete responses to all questions asked by the claims representative. Specifically your client will be asked:

1) Name

2) Sex

3) Telephone Number

4) Birthdate and birthplace and whether there's a birth record

5) Social Security Number

6) Names, ages, relationship to your client, marital status or student status of any other disabled person in the household.

7) Citizenship status

8) Whether or not he or she is a recipient of or prior applicant for benefits under SSI, other SSA programs, Medicare, Workmen's Compensation, public assistance, and so forth.

9) Whether or not he or she was ever in the military, worked for a railroad, or worked for any employer with a pension plan. (This is so the SSA can determine whether there are any other benefits for which your client should apply.)

10) Income and Resources -- sources and amounts and expected sources and amounts of income. Resources in terms of value of home (if owned), value of vehicles, life insurance policies, cash on hand, checking and savings accounts, personal and real property.

11) Medicaid Number (if your client has a number)

12) About the disability -- what it is, when it started, when it finally disabled your client, how it affects your client and interferes with working.

13) Work history -- last date your client worked, job duties, amount worked (hours per day), level of attendance, your client's "usual" job in the 15 years before becoming disabled or the kind of work engaged in for the longest period of time, date your client stopped working at his or her "usual" job and whether or not the disability caused the discontinuation of "usual" work.

14) Information about medical (and other) records -- name, address and phone number of doctor who has latest medical records on your client, how often this doctor is seen, first and last dates this doctor was seen, reasons for visit, type treatment received; same information for any other doctors seen for this illness (the one on which claim of disability is being based); names and addresses of hospitals or clinics at which your client was treated for this illness, patient or clinic numbers, dates of admissions and discharges, whether your client was an inpatient or an outpatient, reason for treatment, type treatment received; names and addresses of other agencies (VA, Workmen's Compensation, VR, Division of Family and Children Services, or other human service agencies) seen by your client because of this illness; claim number or agency identifi-

cation number, dates of visits, type treatment or service received; whether any doctor has told your client to limit his or her activities in any way.

5) Educational information -- highest grade completed; whether or not any trade or vocational schools were attended, dates of attendance and how any vocational training was used in the work your client did. If there has been special education the facility and teachers identified along with dates.

6) Daily activities -- your client will be asked to describe his or her daily activities in the following areas: household maintenance (including cooking, cleaning, shopping and odd jobs around the house); recreational activities and hobbies; social contacts; and other (driving a car, riding a bus, etc.). This is an important part of the form as it serves to elucidate the level of functional impairment resulting from the disability. Again, you should encourage your client to answer the questions honestly and completely even though these may seem the least relevant to the application process.

It probably goes without saying that most claims representatives don't xpect all of these questions to elicit complete responses. Persons not exper- encing any disability would have problems responding to the entire list of uestions. Your client will not be penalized in any way for not being able to ive complete information. However, the time it takes for the SSA to make a etermination of eligibility depends on the amount of information available at he time of application. Any assistance you can provide your client in being repared for the application process will be of great benefit in expediting SI payments if, in fact, your client is eligible for SSI.

In much the same way as some senior citizen groups have volunteers "on call" to assist elderly persons in filing income tax, your facility could have a person or persons "on call" to assist clients in applying for SSI benefits. This seems to be a useful role for a family member or for a volunteer. In fact, in cases where the client is not likely to be able to respond well to an interview with a claims representative, you may wish to ask someone to go with your client to the Social Security Office. Claims representatives are generally receptive to such assistance by a third party.

It can't be stressed enough that complete information from your client nd complete and prompt information from the facilities where your client has eceived services are crucial elements in the timeliness and accuracy of the etermination of eligibility for SSI. Remember, too, that incomplete informa- ion often results in the purchase by the DDB of a consultative examination efore a disability determination can be made. Such examinations are an addi- ional cost to the taxpayer, often inconvenient and confusing to your client, nd will certainly add time to the disability determination process.

re-Discharge Processing (see also, page 12)

When a person is ready to be discharged from a non-Medicaid public inpatient acility and that person is not currently eligible for SSI, a claim can be filed n the person's behalf. If there is sufficient advance notice, eligibility can be etermined prior to discharge and eligibility determinations which are contested y the applicant can even go through the appeals process, but no payment will be

initiated by the SSA while the person is an inpatient at a non-Medicaid public facility.

In addition to the fact that an inpatient in a non-Medicaid public facility is not eligible to receive SSI, the person's community address and the name of the representative payee, if appropriate, must be known to the SSA before payment will be initiated. The representative payee must also have signed the necessary agreements to receive payment on behalf of the SSI recipient. The most costly problem, in terms of the timing of payments, is the failure on the client's part or on the part of the facility assisting the client, to get the representative payee in to the local Social Security Office to sign the necessary forms.

Eligibility for SSI, once determined, is usually good for a year. So, if your client remains in the facility for awhile after SSI has been approved, payments can still be initiated upon discharge. However, if your client remains in the facility for a year or more, eligibility has to be redetermined.

The rules regarding evidence of eligibility are the same for pre-discharge applications as they are for any other kind of application. In addition to medical evidence of record, specific information regarding the degree and description of daily activities, interests, personal habits and relationships is also essential. See page 3.

For pre-discharge processing to initiate resumption of regular SSI payments for persons who have been in a Medicaid facility or a non-Medicaid public facility less than a year but more than a month, the client or facility staff or some other person should call the local Social Security Office nearest to where the client's community residence will be and tell them about the discharge. Again, the person's community address and the name and address of the representative payee, if appropriate, must be known before the SSA can reinstate the payment process.

The Monthly Payment

With maximum speed and cooperation on the part of each party involved, it should only take six weeks or so from the time your client makes a claim (applies) for SSI until he or she is determined eligible or ineligible. Upon determination the claimant is mailed a notice of the results of the determination. This has been known to arrive after the first SSI check for claimants determined eligible. If your client receives a check from the SSA, chances are it's because he or she was determined eligible. Tell your client to cash it.

Monthly federal SSI payment amounts are established by law and are standard throughout the country. Some SSI recipients in some states receive more than the standard amount because their state supplements the basic federal SSI payment. As of this writing (April 1980) the basic amounts are:

July 1, 1980:

$238.00	$208.20 - for an eligible individual considered to be living in his or her own household.
$357.00	$312.30 - for an eligible couple considered to be living in their own household. Issued in separate checks, 1/2 to each.
$158.67	$138.80 - for an individual considered to be living in the household of another.

July 1, 1980:

$238.00 $208.20 - for an eligible couple considered to be living in the household of another. Issued in separate checks, 1/2 to each.

The standard payment amounts have increased several times since the first payments were made in 1974 and they usually increase each July in accordance with the cost of living. Payments will increase 14.3% in July 1980. The $25.00 maximum while institutionalized in a Medicaid facility will not increase.

The standard payment may be reduced because of the receipt of other income. In the Social Security Handbook cited in the preface, there are pages and pages of regulations about income, earned and unearned, which is used or excluded in determining the amount of SSI benefits an individual will receive monthly. You should count on your local Social Security Office to know those regulations or, if you're stout of heart, you may wish to order the Handbook and learn them. However, you should not count on your local Social Security Office to have any influence over the amount of money your client receives each month beyond accurately reporting what the claims representative is told by your client. Information from the claim is fed into a computer and the amount is calculated in accordance with SSA regulations which have been programmed into the same computer. If your client receives a check he or she feels is for an incorrect amount, he or she can ask the local Social Security Office to have the amount verified. If, after verification, your client remains unsatisfied, the correct process is to ask the claims representative to initiate an appeal. The role of the claims representative is to professionally interview your client and file any claims or appeals he or she may wish to make. The local Social Security Office has no control of the timing or amount of checks, beyond the claimstaking process.

When your client applies for SSI, he or she will be asked whether permission is given for the SSA to check any statement made in connection with the application and to ask employers for information about wages. Declarations of income are verified by the SSA.

Representative Payees

The basic policy of the SSA with respect to the appointment of a representative payee (i.e., a person selected to receive cash benefit payments on behalf of a beneficiary) is that every adult has the inherent right to manage his or her own benefit payments unless found incapable to doing so. Evidence of incapability must be submitted before a representative payee will be chosen to be paid benefits on the beneficiary's behalf. Evidence may be medical, legal or "other acceptable evidence of incapability". When the claims representative interviews your client, he or she will try to establish whether a representative payee might be necessary. If so, the claims representative will send along with the Disability Report to the DDB a request that the DDB secure an opinion regarding capability of client from the treatment facility which most recently treated your client and for which the client seigned a release. Lay evidence, that is, evidence other than medical is considered "supplementary evidence..." of incapability. So, your facility's physician does need to make a statement. The staff person most familiar with your client may submit objective statements of fact which make clear the client's money-management capability.

The selection of a representative payee is often a problem. The usual order of preference of the SSA in selecting a payee is as follows:

A) The legal guardian or spouse (or other relative) who has actual custody of the beneficiary or who demonstrates a strong concern for the personal welfare of the beneficiary.

B) A friend who has custody (actual, not legal) of the beneficiary or who demonstrates strong concern for the beneficiary's personal welfare.

C) A public or nonprofit agency or institution having actual custody of the beneficiary.

D) A private institution operated for profit having custody of the beneficiary and licensed under applicable state law.

As you can see, almost anybody can be a representative payee. Persons who are not friends or relatives and who do not have actual custody of the beneficiary, of payments do not fall into the order of preference. However, they are not necessarily excluded and Social Security staff indicate that sometimes a boarding home operator or person equally unrelated to the beneficiary may be the only available payee. You can assist your client and the SSA by helping locate a responsible person to act as representative payee. Persons whose disability is caused by or exacerbated by alcohol or drug addiction are required to have a representative payee.

The guidelines used by the SSA for "considerations in determining the qualifications" of a representative payee are as follows:

1) the payee's past or current custody of the recipient.

2) the payee's demonstrated ability to plan for the recipient.

3) past or present financial assistance provided to the recipient by the payee.

4) the payee's ability to recognize the needs of the recipient as evidenced by personal contact, gifts, visits, letters, etc.

5) the payee's relationship with the recipient and his or her family, home provider or guardian. (For example, a parent of an individual would not be an appropriate payee if the individual lived with the other parent and there was considerable hostility between the parents.)

6) geographic distance between the payee and the recipients.

7) the payee's financial condition.

If you have questions about the person you have in mind as a responsible payee, talk it over with one of the claims representatives at your local Social Security Office. Any person who agrees to serve as the representative payee for an SSI recipient will be required to sign certain agreements with the SSA about the use of the SSI payments and the reporting requirements for representative payees.

Under the section related to the relationship between SSI and supportive living you will read that family care home providers are often the representative payees and that the SSA welcomes information about whether or not the home provider is meeting the client's needs. No matter who the representative payee is, the SSA will welcome information which may indicate a problem. Representative payees are accountable for their use of benefits and are required to provide periodic written reports to the SSA, but in reality there are not sufficient numbers of SSA staff to adequately monitor benefit expenditures by all representative payees. However, the SSA does investigate complaints. So, if your client suspects abuse, you may wish to assist him or her in contacting the Social Security Office.

Redeterminations

The eligibility of each recipient for SSI payments must be redetermined periodically to insure that eligibility continues and that payments are in the proper amount. Eligible individuals are contacted at least annually for this redetermination. Essentially, your client will be expected to provide the same kind of information that was given at the time of application. However, what was requested verbally by the claims representative at the time of application might have been much easier to respond to than what shows up in the mail much later. If your client receives a form in the mail, with the return address of either the Baltimore, Md. or the local Social Security Office anytime within three months to a year after being determined eligible for SSI and this form asks questions like "Do you own a boat?" or "Have you left the country in the past year?" or "Have you enrolled in school?", it is probably a redetermination form. You may wish to counsel your client to expect a redetermination of eligibility form and not to worry about it, but just to complete it and return it as soon as possible.

Your client is asked to submit evidence of factors subject to change such as income, resources and the like. In addition, your center or facility may be asked to provide evidence of continued disability. The rules regarding "evidence" are the same for redeterminations of eligibility as they are for initial determinations.initial determinations.

Denials

If your client is not eligible, a notice will arrive in the mail indicating that the claim has been denied. It will give a reason for the denial. Currently, about two-thirds of all claims are denied. Most claims are denied because the disability is determined not to be severe enough to eliminate the possibility of substantial gainful activity.

If your client feels his or her claim of disability was incorrectly denied, an appeal can be made through the local Social Security Office. Remember, your client is not assigned to a claims representative and, particularly in larger offices, subsequent contacts with a particular office may not result in your client receiving assistance from the claims representative initially involved. The client's file is all that is needed to initiate the appeal, however, so any claims representative should be able to assist.

Additional Relationships to Vocational Rehabilitation

In addition to its role in the disability determination process, the Rehabilitative Services Division (RSD) is often involved in other ways. When an individual applies for SSI, the individual, if under 65, may be referred to a VR counselor for consideration of appropriate rehabilitation services. Individuals who are SSI eligible but who refuse VR services without good cause will not receive payments. When the DDB makes a disability determination on an SSI applicant, the applicant's file is screened for appropriateness of referral to a VR counselor. If there are some obvious reasons for expecting that VR services would be of very limited assistance to the individual (applicant past retirement age, disability too severe, evidence in the file of RSD's previous unsuccessful attempts to work with the recipient, etc.) the applicant will probably not be referred to a VR counselor. If, however, there is reason to believe the applicant might benefit from VR services, the RSD District Office nearest the applicant's residence is notified. All applicants are then contacted by a local counselor. This contact may be by phone or by mail. Your client should be encouraged to followup on this contact and to participate with the VR counselor. There are two obvious reasons for this. First, the VR counselor may be able to assist your client in returning to productive activity. Second, the SSA is required by law to suspend payment of SSI (or SSDI) to any recipient who has been referred to RSD and who refuses to accept, without good cause, VR services.

There is in effect a collaborative working agreement between the Rehabilitative Services Division of the Department of Social and Rehabilitation Services and the Mental Health and Residential Services Division of the Department of Institutions.

RSD may also be involved in the development of self-support plans (SSP's). The SSI regulations provide, in general terms, that money set aside in a plan to make the SSI recipient economically self-supporting will not be used to reduce the amount of SSI payments. The SSA does not require that the applicant develop a formal written plan. An individual may, for example, when applying for SSI, state that he or she is paying for training or is purchasing a piece of equipment for future occupational use. The claims representative will assist the applicant in formalizing the plan at that time. The SSA will then verify that the person is enrolled in a training program or is making payments on the equipment, and will reduce the monthly amount of the applicant's countable income by the monthly expenditure for the training or the equipment, before assessing income eligibility for SSI. Although clients may design their own plan for self-support, this is often done as a part of designing a VR plan in coordination with a VR counselor. If your client is not working with a VR counselor but does have occupational goals, you could assist by helping formulate a self-support plan which your client can present to the Social Security claims representative. If an SSP is developed after your client starts receiving SSI checks, the local Social Security Office can be notified at that time. It may be that the amount of SSI would increase as a result.

Any money (except for payment received for work in a sheltered workshop) or in-kind support and maintenance (meals and shelter) your client receives from RSD generally is not used to reduce the SSI payment if your client is in the training phase of a rehabilitation program. On the other hand, if your client works in a sheltered workshop because he or she is unable to find employment in the competitive labor market and if normal payroll taxes (income tax, social security) are withheld, the payments are considered earned income. Earned income reduces an SSI check at a much lower rate than unearned income (income or benefits received which are not the result of employment) and generally the amount earned at a sheltered workshop will have little impact on

the SSI check. In some few cases, payments in a sheltered workshop may be so large that they lead to a determination that the recipient is no longer disabled because he or she is capable of self-support. Your client must report all earned or unearned income at the time of application for SSI and at any other time there's a significant change in income.

Relationship to Medicaid

In Montana, all SSI recipients are eligible for Medicaid. There are some adult Medicaid recipients, however, who are not eligible for SSI (usually because their income is too high). An application for SSI is also an application for Medicaid eligibility. If your client is not eligible for SSI, the letter from SSA telling your client this will also say he or she may be eligible for Medicaid and will instruct your client to get in touch with the local County Welfare Office. If your client is eligible for SSI, the letter will say "AN AGENCY OF YOUR STATE WILL ADVISE YOU ABOUT THE MEDICAID PROGRAM. IF YOU HAVE ANY QUESTIONS ABOUT YOUR ELIGIBILITY FOR MEDICAID OR NEED IMMEDIATE MEDICAL ASSISTANCE YOU SHOULD GET IN TOUCH WITH YOUR LOCAL COUNTY WELFARE OFFICE." SSA computers pass along to the Division of Economic Assistance (DEA) computers information about who is eligible for SSI. In turn, DEA in Helena will mail the SSI recipient a Medicaid card each month. They will also send out any notices if Medicaid eligibility stops. A person who is eligible for SSI may also be eligible for Medicaid during the 3 months before he or she applied for SSI if there were unpaid medical expenses from that period and if the person met the SSI eligibility requirements during that period.

A Medicaid facility is defined as a medical or psychiatric facility in which Medicaid pays over half the cost of care. When an SSI recipient is in a Medicaid facility, the maximum monthly SSI payment is $25, to be used for the recipient's personal needs while in the facility. This only applies to months where the individual is considered an inpatient or patient in a Medicaid facility for every moment of the month, except for brief furloughs which do not cause a break in inpatient status. Any income that accrues to the SSI recipient is used to reduce the $25 payment. However, even if the inpatient's income is more than $45 a month and the inpatient loses his or her SSI eligibility, Medicaid eligibility will probably remain in effect for the duration of the stay in the Medicaid facility. The individual will probably be eligible for Medicaid under the "Medicaid Assistance Only" (MAO) program; DEA will review the case and make a decision about eligibility. When SSI recipients receive notice that they are no longer eligible for SSI because they are in a Medicaid facility and their income is too high, they can apply for MAO-Medicaid by contacting the DEA office, if the DEA office doesn't contact them, first. (Normally when DEA computers receive information that an SSI recipient is being suspended for this reason, the information is passed on to DEA and DEA contacts the person.) No person can make an SSI recipient in a Medicaid facility use the monthly $25 SSI payment to pay the facility's bill. However, SSI recipients who are in a Medicaid facility for a long time and who don't spend the whole $25 each month should be careful that their "personal use" funds and any savings they have outside the facility don't add up to more than $1,500. as this would eliminate SSI.

If an SSI recipient goes into a non-Medicaid medical or psychiatric facility the SSI is left at its current amount or stopped altogether, depending upon whether the facility is private or public. When it is a private facility, the recipient's

financial needs are considered to be the same or greater and SSI is not affected. When the facility is a public facility, it is assumed that the government agency operating the facility has assumed the cost of care and SSI is suspended if the recipient is in the facility longer than a month. Unless the recipient is in the facility for a year or more, SSI can be reinstated without the need for a redetermination of eligibility. However, when SSI has been suspended for a year or more the former recipient must reapply for benefits. If your client goes into any Medicaid facility or non-Medicaid public facility and the inpatient stay is expected to be longer than a month, he or she should notify the local Social Security Office so that SSA doesn't make an overpayment which would have to be returned.

Relationship to Emergency Benefits

Some counties in Montana have "interim assistance" programs for SSI claimants which are county financed. These counties are:

Carbon	Fergus	Lewis and Clark	Richland
Blaine	Flathead	Musselshell	Sheridan
Carter	Glacier	Petroleum	Silver Bow
Custer	Golden Valley	Phillips	Wheatland
Dawson	Hill	Pondera	Wibaux
Fallon	Judith Basin	Ravalli	Yellowstone

The program is handled by the local County Welfare Offices.

Under this program, the county makes monthly assistance payments to some SSI claimants while they are waiting to hear whether their SSI claims are approved. The payments vary from about $125-$150/month, depending on what other resources the applicant has, how severe the disability is, how many people in the household apply for SSI and whether they have food stamps. If the SSI claim is approved, Social Security sends the first check (including amounts for past months) to the county, the county keeps an amount equal to what they have paid in interim assistance, and sends the claimant (recipient) the balance within 10 days. If the SSI claim is denied, some counties stop the interim assistance. Other counties will pay interim assistance while the claimant appeals the denial notice.

If the claimant goes into a county office and he or she appears to be eligible for SSI, the county will take the application necessary for "interim assistance", ask the claimant to sign a form authorizing Social Security to send the first check to the county, and tell the claimant to take a copy of the form to the Social Security Office and file for SSI. The Social Security Office considered that the SSI application was filed the same day as the authorization form was received in the Social Security Office. If a claimant files first with SSI and he or she seems to need immediate financial assistance, the claims representative will refer the claimant to the county for interim assistance.

Relationship To State Supplemental Payments

The Montana legislature authorized the Department of SRS to make certain supplemental payments to recipients of SSI out of State funds. A State supplemental payment is made to an individual who receives SSI and is residing in a licensed residential care facility. Examples of residential care facilities are children or

adult foster care homes, specific room and board homes, rest homes, community homes for the developmentally disabled and group homes for the mentally ill. The supplemental payment becomes a part of the individuals SSI check and varies from a basic $49 monthly supplement to a maximum $104 monthly supplement depending on the individual's needs and the residential setting.

Relationship to the Veteran's Administration

There are no formal links between the SSI program and VA benefits at the regional or local level. However, the programs are connected in two ways:

____ When applicants file for SSI, they may be required to file for VA benefits because the SSI law says a person "must file for all other benefits to which he might be eligible:. If the claimant is a veteran or the parent, widow, or child of a deceased veteran, the Social Security Office will tell the claimant whether it appears he or she would be eligible for a VA payment. If it appears the claimant is eligible, he or she is given written notice to file an application with VA within 30 days. This notice is also sent to VA, so VA can notify the SSA when the person files. SSA will not hold up making a payment while waiting to receive notice from the VA if the person is otherwise eligible for SSI. However, SSI payments will be suspended if the recipient does not file for VA benefits within the thirty day period.

____ The second connection is through individuals who already receive VA payments. When claimants are receiving VA pensions, their SSI checks are reduced dollar-for-dollar by the amount of the VA pension. This is because the VA pension is also a needs-based payment and duplication of federal payments for the same needs must be avoided. A new "Improved Pension Act" went into effect January 1979. Most people who receive a check under the Improved Pension Act are not eligible for SSI because their VA check is more than the SSI payment. When a person receives a VA compensation check, all of the compensation check except the first $20 a month is used to reduce the SSI check. If a VA recipient received an "Aid and Attendent" payment -- a payment to purchase household services for homebound VA recipients -- or receives VA educational payments (usually called GI Bill) -- the SSI check is not reduced by the amount of the aid and attendent payment or by any payment for tuition, books, and school fees.

Periodic comparisons are run by computer of persons receiving SSI benefits and persons receiving VA benefits. These comparisons inform the SSA of persons who are eligible for both SSI and VA benefits. However, this computer check doesn't provide complete or current information on the type VA benefit being received. Claimants who are receiving a check from VA should be prepared to furnish a copy of correspondence received from VA (especially an "award notice") to help the SSA tell if they are receiving pension or compensation or aid and attendent payments, etc.

Relationship to the Supportive Living Program

Relationships between the SSA and the group homes programs are unstructured and vary considerably from area to area. If an individual in supportive living placement applies for SSI, it is important that the individual tell the claims representative so that the claims representative can make the notification. It is also important because if SSA does not know about the placement, the claimant may be considered to be living in the household of another and his or her payments may be reduced by one-third.

Usually, though, the relationship exists because the home care provider applies to be the claimant's representative payee -- the payee on the SSI checks. Most SSA contact with the program, then, is through the home care provider. However, SSA still welcomes information from the supportive living worker about whether the home provider is taking care of the recipient's needs, if the recipient moves to a different home provider, leaves the supportive living program, etc.

Relationship to Food Stamps

Beginning in August, 1980, the local Social Security Offices began taking applications for U.S.D.A. Food Stamps from eligible SSI recipients who live alone or who live in households where all other residents are SSI recipients.

People who are not recipients of SSI may be eligible for Food Stamps and other SSI recipients may be eligible for Food Stamps, but the SSA will only take Food Stamp applications for those persons who are SSI recipients and who live alone or in households where all other residents are SSI recipients. All other persons who wish to apply for Food Stamps will be referred to DCS.

The Targeted Jobs Tax Credit Program

The Targeted Jobs Tax Credit Program (TJTC) provides a tax credit to employers who hire (or who have hired since September 26, 1978) handicapped persons who fit into one of the following seven categories:

1) Recipients of Supplemental Security Income (SSI) payments;

2) Handicapped individuals referred from vocational rehabilitation;

3) Youth, 18 through 24, in economically disadvantaged families, i.e., with income the preceding 6 months less than 70% of the Bureau of Labor Statistics lower living standard:

4) Vietnam-era veterans under 35 who are economically disadvantaged;

5) Recipients of general assistance (state or locally financed welfare) for 30 or more days;

6) Youth, 16 through 18, participating in an approved cooperative education program; and

7) Ex-convicts (convicted of a felony) who are economically disadvantaged and hired within 5 years of release from prison or date of conviction, whichever is later.

In order for an employer to receive the tax credit, the employee or prospective employee must first be certified eligible by the local job service office of the Department of Labor and Industry (DOLI). Persons who are asking to be certified eligible because of SSI recipiency will be asked to go to the local Social Security office and secure a voucher which will verify their SSI status. When they return this form to the local job service office they will be certified eligible. The local job service office will know which employers in the area are interested in the TJTC program and should be able to assist your clients with job referrals.

Purpose, Source and Administration

Social Security Disability Insurance (SSDI) is a monthly cash benefit for a disabled worker and his/her dependents. The segment of the federal Social Security Act under which SSDI is paid is Title II. It is sometimes referred to as "disabled worker's benefits" to distinguish it from benefits for other disabled persons such as disabled widows, widowers, sons or daughters, or disabled persons with no work history. Unlike SSI, SSDI is an insurance acquired through contributions which were deposited to the Social Security Trust Fund by your client and his or her employer. That's why eligibility for SSDI depends on your client's having worked. It is also why an eligible person is eligible regardless of income unless enough to be considered substantial gainful activity (SGA). An eligible person is, in effect, collecting on paid insurance.

The SSDI program is administered by the same agencies that administer SSI and DDB plays the same role in determining disability.

Criteria for Eligibility

Disability, for purposes of determining eligibility for SSDI, is defined in exactly the same way as it is for SSI. In fact, the differences in the two programs are only these:

1) SSDI is dependent on the individual's work history, whereas SSI may be available to persons who have never been employed.

2) SSDI is independent of the individual's level of indigency, other than SGA, whereas SSI is only available to persons with limited or no other resources or income.

The following explanation of SSDI relates to those persons who were employed, met the requirements for "disability insured status" and then became disabled. If your client is the son, daughter or spouse of a deceased, retired or disabled worker, special regulations will apply which are not explained here and you should check with your local Social Security Office for details.

A person achieves "disability insured status" if he or she has a sufficient number of quarters of work credited to his or her social security earnings record. Generally, this means the worker is fully insured if he or she worked for at least one quarter of each calendar year after 1950 or after he or she reached 21 years of age. No one can be fully insured with fewer than six quarters of work. A person with forty quarters of work is fully covered for retirement purposes for life. Currently, (1980) a quarter of work is generally defined as one in which an employee had reported covered earnings of $290 or more. Prior to 1978, the amount of $50. For self-employed persons or agricultural workers, the amount was $100. Calendar quarters are January through March, April through June, July through September and October through December. In conjunction with fully insured status, a person must also meet disability insured status. This means that twenty of the forty quarters immediately preceding the disability must have been worked in social security covered employment.

There are some exceptions to these general criteria for determining insured status. For example, a person disabled before age 31 who does not have sufficient quarters of coverage may still be eligible. The claims representative at your local Social Security Office should be able to tell your client whether he or she would be eligible based on work history.

The Application Process

Often, when an individual goes to apply for SSI, the claims representative will also either take a claim for SSDI at the same time or will refer the applicant to another claims representative to take the claim. In larger offices, claims representatives often specialize in SSI claims-taking or SSDI claims-taking and this usually works out to the applicant's advantage in time saved. The reason your client may be asked to sit through both interviews is because applicants are often eligible for both SSI and SSDI in their current financial situations. However, after SSDI becomes available (after five full months after the month of onset of the disability) the SSI is reduced or stopped. So, it is to the applicant's advantage to have both determinations made at once and to have SSI payments available while SSDI is being processed (or while the five month waiting period is being satisfied). This explanation is offered in view of the fact that the length of the process is often confusing and tiring and applicants don't always understand why two different claims representatives may ask questions which seem duplicative. You may assist your client by explaining the possibility that two claims could be taken during his or her visit to the Social Security Office.

If your client is not eligible or interested in applying for SSI, but feels he or she may be eligible for SSDI, the process is the same as that of applying for SSI and the information needed by the claims representative is essentially the same. The type of information needed by the DDB is the same for SSDI as it is for SSI. In fact, when a claim is made for both the disability determination is done for both programs at the same time and the decision applies to both programs.

The appeals process is essentially the same for both programs.

The Payment Process

The amount of monthly disability benefits paid to a worker and his or her family is based on his or her earnings for the periods of time employed and on the numbers of eligible family members present in the household. Amounts vary greatly from applicant to applicant and only the Social Security Office could tell your client how much to expect in benefits.

There is a five calendar month waiting period after a worker becomes disabled before he or she is eligible for SSDI. The worker is not entitled to benefits for any month during the waiting period. A person who has been disabled but who didn't immediately apply for SSDI may be paid benefits retroactively up to a year prior to application, providing the five-month waiting period was satisfied before the retroactive period.

Relationship to Vocational Rehabilitation

The relationship with the Division of Rehabilitative Services is the same for SSDI recipients as it is for SSI recipients. The DDB in Helena determines disability and referrals are made to VR District Offices just as they are for SSI recipients or claimants.

Relationship to Medicaid

A person who is receiving SSDI is usually receiving too much money to also be eligible for SSI and with the termination of SSI, Medicaid eligibility usually ceases. So, it can be said that the only relationship between SSDI and Medicaid is that SSDI usually serves to eliminate Medicaid eligibility.

Relationship to Medicare

Medicare protection is available for beneficiaries of SSDI who are under age 65 and who have been receiving SSDI payments for at least two years. At age sixty-five, Medicare protection is automatically available, whether or not the individual is disabled.

If your client has been a beneficiary of SSDI for two years or if your client reaches age 65, he or she will be mailed a "Health Insurance Card" from the Baltimore, Maryland central office of the SSA, certifying Medicare eligibility status.

There are two parts of Medicare. Part A of Medicare provides hospital insurance protection. Part B of Medicare is called "Supplementary Medical Insurance Benefits" and partially pays for medical (mainly physician) services. Thus it covers physicians' and other practitioners' services, additional home health visits, and a variety of "medical and other Health services" not covered under Part A.

A monthly premium is required for Part B. However, if an individual's SSDI payment is so low that he or she is also eligible for SSI, the DEA automatically pays the Part B premium.

CONCLUSION

The SSI and SSDI programs are part of the Social Security Act which was broadly conceived "to promote the general welfare". It sometimes seems that this enormous task has also been assigned to the mental health system. We are learning it cannot be accomplished without assistance. We need to ask our communities to support our efforts as well as those of the Social Security Administration and the many other agencies involved in "promoting the general welfare".

If this booklet serves as a handy reference for you in your work with clients who are applying for SSI and SSDI it will have accomplished its major purpose. If it also triggers your thinking about how others might provide those clients with assistance and how this booklet might be used to train other persons to provide assistance, it will have accomplished an even broader goal: that of promoting community support for clients of the mental health system.

APPENDIX A

(See page 3, text of this booklet)

NAME _____

SSN _____

MENTAL HEALTH QUESTIONNAIRE

(1) Degree and description of restriction of daily activities.

(2) Degree and description of constriction of interests.

(3) Degree and description of deterioration in personal habits.

(4) Degree and description of impaired ability to relate to other people.

Treatment Facility _____

Signature _____

Date _____

COUNTY WELFARE OFFICES

COUNTY	DIRECTOR	MAILING ADDRESS	CITY	TELEPHONE NO.
Beaverhead	Wayne H. Contway	PO Box 225	Dillon 59725	683-2142
Big Horn	Jane Kukes	PO Box 426	Hardin 59034	665-1906 & 7
Carbon	Helen M. Bohnert	PO Box 670	Red Lodge 59068	446-1302
Cascade	Harold McLaughlin	PO Box 1546	Great Falls 59403	761-6605 ext. 30
Choteau	Olga F. Erickson	PO Box 456	Fort Benton 59442	622-5432 & 3
Custer	Dorothy E. Drake	Courthouse Bsmt.	Miles City 59301	232-1247
Powder River	"	PO Box 424	Broadus 59317	436-2621
Garfield	"	PO Box 97	Jordan 59337	557-2297
Dawson	George H. Shanley	PO Box 281	Glendive 59330	365-4314
McCone	"	PO Box 204	Circle 59215	485-3425
Prairie	"	PO Box 531	Terry 59349	637-5570
Deer Lodge	Eudora Fald	PO Box 1177	Anaconda 59711	563-8421
Fallon	Betty L. Mueller	PO Box 759	Baker 59313	778-2512
Carter	"	PO Box 759	Baker 59313	775-8751
Wibaux	"	PO Box 759	Baker 59313	795-2403
Fergus	Verlin E. Gaskill	308 Bank Elec. Bldg.	Lewistown 59457	538-7468
Musselshell	"	PO Box 304	Roundup 59072	323-2101
Judith Basin	"	PO Box 416	Stanford 59479	566-2461
Petroleum	"	PO Box 304	Winnett 59087	429-5311
Wheatland	"	Drawer "U"	Harlowton 59036	632-5611
Golden Valley	"	Drawer "U"	Harlowton 59036	568-2231
Flathead	Ruth E. Davis	PO Box 1096	Kalispell 59901	755-5300 ext. 26
Gallatin	Robert K. Sybrant	Courthouse, 3rd Floor	Bozeman 59715	587-3193
Glacier	Lowell McGhie	PO Box 356	Cut Bank 59427	873-5534
Hill	Nancy K. Neibauer	321 4th St.	Havre 59501	265-5481 ext. 42
Blaine	"	PO Box 1088	Chinook 59523	357-2276
Liberty	"	300 4th St. Courthouse	Havre 59501	334-3841

Lake	Bonnie M. Mueller	PO Box 847	Polson 59860	883-5211	
Lewis & Clark	Norman Waterman	316 North Park	Helena 59601	442-2020	
Broadwater	"	DPW	Townsend 59644	266-3447	
Jefferson	"	PO Box 145	Boulder 59632	225-3327	
Lincoln	William H. Willard	418 Mineral Ave.	Libby 59923	293-7781	est. 270
Madison	Emery Smith	PO Box 75	Virginia City 59755	843-5361	
Mineral	Edna S. Brader	PO Box 626	Superior 59872	822-4551	
Missoula	Elizabeth Johnson	301 W. Alder	Missoula 59801	SS-721-5700	EA-543-6641
Park	Juanita Freeman	414 E. Callender	Livingston 59047	222-1173	
Meagher	"	PO Box 514	White Slph.Spgs. 59645	547-3752	
Pondera	Rita R. Christiaens	20 4th Ave. S.W.	Conrad 59425	278-5222	
Teton	"	DPW	Choteau 59422	466-5721	
Toole	"	PO Box 272	Shelby 59474	434-5022	
Powell	Frieda G. Howery	DPW	Deer Lodge 59722	846-1092	
Granite	"	PO Box 448	Philipsburg 59858	589-3671	
Ravalli	Alice B. Thane	PO Box 5020	Hamilton 59840	363-1944	
Richland	Bonne Lu Perry	221 5th St. S.W.	Sidney 59270	482-2015	
Rosebud	Michael Kennedy	PO Box 241	Forsyth 59327	356-2563	
Treasure	"	DPW	Hysham 59038	342-5547	
Sanders	Gwenetta Parker, ET	PO Box 456	Thompson Falls 59873	827-3581	
Silver Bow	Queenie V. Lynch	DPW	Butte 59701	SS-792-0436	EA 792-2351
Sweet Grass	Diane B. Altimus	PO Box 489	Big Timber 59011	932-2566	
Stillwater	"	PO Box 928	Columbus 59019	322-5331	

COUNTY	DIRECTOR	MAILING ADDRESS	CITY	TELEPHONE NO.
Valley	Delores M. Shelton	PO Box 272	Glasgow 59230	654-2252
Phillips	" "	PO Box 1339	Malta 59538	654-2252
Roosevelt	J. T. Brownlee	PO Box 370	Wolf Point 59201	653-1512
Sheridan	"	PO Box 413	Plentywood 59254	765-1370
Daniels	"	PO Box 794	Glasgow 59230	487-2721
Yellowstone	James Greer	Courthouse, Rm. 207	Billings 59101	248-1691

MONTANA

SOCIAL SECURITY REGIONAL OFFICES

BILLINGS
P. O. Box 2501
U.S. Federal Office Building
Room 3412
316 N. 26th Street

Telephone: 406-657-6274

BOZEMAN (Helena)
P. O. Box 1927
Martel Center II
North Third & Lamme

Telephone: 406-587-5271

BUTTE
P. O. Box 3588
501 East Fron Street

Telephone: 406-723-6561

GREAT FALLS
P. O. Box 2347
819 Central Avenue

Telephone: 406-761-0661

HELENA
301 South Park
Drawer 10075

Telephone: 406-449-5208

KALISPELL (Missoula)
301 1st Avenue East
P. O. Box 1996

Telephone: 406-755-6150

MILES CITY (Billings)
P. O. Box 670
713 Pleasant Street

Telephone: 406-232-4282

MISSOULA
P. O. Box 4507
1121 West Kent

Telephone: 406-329-3444

COOPERATIVE AGREEMENT

Between the

Mental Health & Residential Services Division

of

Department of Institutions

and the

Rehabilitation Services Division

of

Department of Social and Rehabilitation Services

I

General Provisions

A. Parties

The parties to this agreement are the Mental Health and Residential Services Division of the Montana State Department of Institutions and the Rehabilitative Services Division of the Montana State Department of Social and Rehabilitation Services. The agreement was developed in conjunction with and is endorsed by the Mental Health Association, the Montana Council of Mental Health Center Boards and the Montana Association for Rehabilitation.

B. Purpose

The purpose of this agreement is to set forth principles and operating procedures which will guide the Mental Health and Residential Services Division, Rehabilitative Services Division and their state and local counterparts in establishing relationships and operational plans to facilitate the provision of services to persons disabled by mental health problems on an effectively coordinated and integrated basis without duplication of effort.

C. Services of Vocational Rehabilitation Agencies

1. Eligibility

The Rehabilitative Services Division has been established to assist in the vocational rehabilitation of physically and mentally handicapped persons. Responsibility for determining eligibility of individuals for these services rests solely with the Department of Social and Rehabilitation Services. The criteria for eligibility for vocational rehabilitation are:

a. The presence of a physical or mental disability which constitutes or results in a substantial handicap to employment; and

b. A reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

2. Services

The following services are available to prepare handicapped persons for gainful employment:

a. Evaluation of rehabilitation potential;

b. Counseling and guidance, including vocationally oriented personal adjustment counseling;

c. Physical and mental restoration services;

d. Pre-vocational adjustment and vocational training;

e. Maintenance, not exceeding the estimated cost of subsistence, during rehabilitation;

f. Transportation in connection with the providing of any vocational rehabilitation service;

g. Services to members of a handicapped individual's family when such services are necessary to the vocational rehabilitation of the handicapped individual;

h. Telecommunications, sensory and other technological aids and devices;

i. Recruitment and training services to provide new employment opportunities in the public service fields;

j. Placement in suitable employment;

k. Post-employment services, necessary to assist handicapped individuals to maintain their employment;

l. Occupational licenses, tools, equipment, initial stocks (including livestock) and supplies, and

m. Other goods and services which can reasonably be expected to benefit a handicapped individual in terms of employability.

D. Services of Mental Health Agencies

1. Eligibility

The Mental Health and Residential Services Division has been established to fund, set standards for and evaluate local mental health centers and to supervise and administer the state institutions. Any person who has a mental health problem may be served by Warm Springs State Hospital, Center for the Aged or a

community mental health center. The resources available and agreements with other agencies will determine the services actually available.

2. Services

The following services are available to some degree to persons with mental health problems.

a. Community Services

- Inpatient services including full time hospitalization.
- Outpatient services including appropriate treatment so that clients can function as they go about their daily lives.
- Partial hospitalization as treatment alternatives to full time hospitalization.
- Emergency mental health services available 24 hours a day, seven days a week.
- Consultation and Education services to a wide range of individuals and entities.
- Specialized services for children and elderly.
- Screening services available to courts and other public agencies considering individuals for inpatient treatment.
- Followup care for mentally ill residents discharged from mental health facilities.
- Transitional residential services for mentally ill residents discharged or diverted from institutions, including living arrangements and access to supportive or rehabilitative services.
- Drug and alcohol abuse services, if not available from other sources.

b. Institutional Services

- Warm Springs State Hospital's primary concern is to provide acute and/or long term care and intensive treatment to mentally ill persons. It offers: 1) Individualized treatment which includes development of individual treatment plans and setting of concrete goals with patients, 2) Evaluation, 3) Group Therapy, 4) Recreational Therapy, 5) Chemotherapy, 6) Education and 7) Occupational Therapy with a graduated training program (basic work habits, pre-vocational skills, workshop and employment at Warm Springs State Hospital and four vocational education programs.

- Center for the Aged's primary concern is to provide long term nursing and intermediate care to mentally ill ambulant clients 60 years of age or older. It offers a homelike atmosphere and family type life with recreation activities and extensive volunteer participation. It offers medical consultation, nursing care and social work services.

E. Statement of Cooperative Effort

In carrying out their responsibilities under their respective laws, the signatories to this agreement recognize overlapping authority and joint responsibility to provide comprehensive, effective services to mentally disabled persons. They recogniz that their ability to provide the needed services, and the economical use of their resources, require careful joint planning and cooperative efforts.

They recognize, further, that no single pattern for cooperative effort can be effective everywhere. In general, with respect to a client for whom the two agencies share responsibility, the mental health agency will provide psychiatric consultation, mental health treatment, and emergency mental health services. The vocational rehabilitation agency will provide services that are needed to facilitate the client's vocational adjustment. The precise roles of each agency in a given geographical area will depend upon the resources available to both agencies and the particular needs of the client.

As they enter into this agreement, the parties recognize the existence of problem which must be overcome if this agreement is to be fully effective. These include differing organizational structures for delivering services, differing traditional models for delivery of services, differing professional training and employment backgrounds o employees, and limited resources to perform the functions assigned them under existing laws. They recognize that a solution to these problems will require specific and well planned strategies, persistence, dedication and good will, and they commit themselves to that goal.

Wherefore the parties agree as follows:

II

Cooperation on State Level

The Mental Health and Residential Services Division and the Rehabilitative Services Division agree to work collaboratively to insure adequate services to the mentally disordered.

1. Each agency will assign a staff member to act as liaison between the two agencies.

2. Rehabilitative Services Division will participate as an active member of the Community Support Project advisory committee.

3. Joint planning will occur around sheltered workshop's service to the chronically mentally ill.

4. Warm Springs State Hospital will house a Rehabilitative Services Division counsellor to facilitate rapid vocational rehabilitation referrals as patient nears the end of his stay at the hospital and to aid in pre-release planning.

5. The Disability Determination Bureau of the Rehabilitative Services Division and the Community Support Project of the Mental Health and Residential Services Division will work closely with the Social Security Office to:

    a. Effect more rapid certification of Supplemental Security Income recipients.

    b. Study ways and means of more efficient casefinding of the chronically mentally ill in Montana.

6. The Rehabilitative Services Division will encourage the Montana Association for Rehabilitation to assume ongoing concern for the mentally disabled.

7. Each agency will encourage and support short term and long term training of individuals serving or expecting to serve the clients of their respective agencies. The two agencies will cooperate in providing training experiences mutually beneficial to rehabilitation and mental health workers. They will collaborate in performing utilization studies of rehabilitation and mental health services/manpower.

8. Both agencies will collaborate in seeking additional sources of funding for services to the mentally disabled and in seeking new areas of cooperation in addition to the above.

9. The Rehabilitative Services Division will confer with the Mental Health and Residential Services Division in setting reimbursement rates for the long-term mentally disabled client.

10. The chief agency executives of the Mental Health and Residential Services Division and the Rehabilitative Services Division will meet at least once annually to review progress being made in carrying out the provisions of this agreement and to discuss other matters of mutual concern to their agencies and constituencies.

11. The rules and policies of each party hereto shall govern questions of confidentiality.

III

Recommendations for Cooperation at Local Levels

Crucial to the success of this agreement is implementation at the local level. Agreements between rehabilitation and mental health agencies at these levels should be entered into with appropriate state agency approval using this agreement as a guide but adapting it to local conditions, reflecting operational responsibilities to be carried out by each party. Cooperative agreements at local levels should address themselves to the following considerations.

A. Parties to the Agreement

Local vocational rehabilitation agencies and local non-profit rehabilitation facilities should enter into agreements directly with CMHCs, psychiatric hospitals, or other types of mental health facilities.

B. Purpose of The Agreement

The purpose of the agreement is to facilitate the expansion, improvement and coordination of services to persons disabled by mental health problems for whom responsibility is shared by mental health and rehabilitation.

C. Services Provided by Each Agency

Since mental health services are what may be described as "cradle to grave" and VR services are available, with minor exceptions, only to individuals of or approachi working age with specified requirements for eligibility, it is very important that th role to be played by both agencies be clearly spelled out, including the characteris- tics of the individuals to be assisted by the VR agency, the services to be provided

by the mental health agency while VR services are underway, and which agency has primary treatment/training responsibility.

D. Continuity of Care

One of the greatest problems in serving mentally ill persons in the community is assuring a continuity of relevant care from initiation of services until need is no longer apparent. Often, several agencies in addition to VR and mental health will be involved. It is important, therefore, that the agreement include procedures that will assure that there are no gaps in service that will be detrimental to the welfare of the client. Consideration should be given to having, in many instances, one professional person in one of the service agencies accept responsibility for smooth flow of services without regard to what agency is providing services at a given time.

E. Referral

Formal referral procedure and arrangements for reporting back on referrals will be provided for.

F. Joint Staff Training and Conferences

Effective referral and service coordination will depend upon a thorough understanding by the staff of each agency of the services available from the cooperating agency and the system through which such services are delivered. To facilitate this mutual understanding, the agreement should provide for interagency training programs for service providers and administrative personnel.

G. Information

The cooperating agencies will exchange information, releases, publications and procedural manuals and instructions of mutual concern to the cooperating agencies.

H. Confidentiality of Client Information

In instances in which both agencies are serving a client they will share information from the files of the individuals being served in accordance with the confidentiality rules of each agency. Such information may be used only for the purpose for which it was made available. Federal and State laws, and the rights of the individuals, will govern this exchange of information.

IV

Termination

This agreement shall remain in effect until amended by mutual consent or until terminated by either party upon thirty (30) days written notice.

V

Effective Date

The effective date of this agreement is July 1, 1980.

Peter S. Blouke, Ph.D., Administrator
Mental Health & Residential Services Division

Date: Aug 15, 1980

W. R. Donaldson, Administrator
Rehabilitative Services Division

Date: Aug 15, 1980

The following organizations endorse the Mental Health and Residential Services Division/Rehabilitative Services Division Interagency Cooperative Agreement and pledge their support and assistance in its implementation.

Ethel A Bond
Montana Council of Mental Health Center Boards

Mental Health Association

Montana Association for Rehabilitation

Training Module for Native American Paraprofessionals

(Task 5)

D. OUTLINE OF TRAINING PROGRAM

Introduction

The Department of Social Work, University of Montana, is pleased to submit this training proposal to the Montana United Indian Association for consideration as part of a larger proposal designed to improve mental health services for urban Indian populations. We share a common perception of the urgency of improving services, and are delighted to be able to offer an instructional program for outreach workers. We believe that what is noteworthy about this project is both the emphasis on improving the accessibility of services to urban Indians, but also improving the quality and nature of service provided under the auspices of community mental health centers throughout the state of Montana.

Foreword

This proposal assumes that it is desirable for the outreach worker's training to be primarily skill-oriented. That is, outreach workers need to be able to discriminate the appropriate situations in which intervention is required, need to initiate that intervention primarily through the roles of advocate, mediator, broker and occasionally a responsive direct helper. The program described below is designed to provide the necessary skills. The proposal further assumes that the most useful form of skill improvement is to be found on the job in the assigned work settings. Training for supervisors to develop trainee skills through on the job training is therefore included along with follow-up workshops by the principal trainers in field settings. The final assumption is that the trainees are selected with a predilection toward psychological-mindedness, and at least a beginning ability to

assume the role of a conferee with supervisors and others to both provide information purposefully and to gain and utilize information from supervision for further skill development.

We feel the training component of this project should visibly reflect the cultural values of Indian culture and be built on the strengths of the trainees. We also believe that training should be conducted in such a way as to strengthen the relationship between supervisors and paraprofessionals because that relationship is the key to the paraprofessional receiving practical assistance in the conduct of the job. The relationship between supervisor and paraprofessional will also have a great impact on the degree to which community mental health centers can learn more about the needs of urban Indian clientele and be willing to adjust and modify their provision of services to this group.

Training Modules

Below are listed the major training modules of the program. These instructional units, of course, vary in time and length, but consistently are organized toward providing outreach workers with the skills necessary to perform their function. The total series of instructional units is designed to be completed within twenty instructional days. Units have been developed both for trainees and, as can be noted below, for supervisors as well. A description of the instructional modules follows:

Orientation Module - This module orients the trainees to the project itself. This module will summarize the need for the project, its basic goals, both short and long-term and the means by which these goals are to be realized with particular emphasis on the outreach worker. The outreach worker's

functions should be described in terms of the three roles of advocate, mediator and broker. The function of other key persons such as the CMC supervisor should also be briefly described. It is suggested that a Medicine Man begin the orientation session with a prayer expressing the hopes of those committed to this project. Secondly, the orientation module briefly describes the topics in sequence of the initial training session.

Objectives: (1) Students will be able to describe the major goals of the outreach project; (2) Students will in general terms describe the role they will play in the achievement of project goals.

The Job of the Outreach Worker - A functional job analysis describing the specific duties of the outreach worker in relation to the three roles of advocate, mediator and broker. This job description will be specific and operational and is intended to be used later as a set of criteria by which the outreach worker's on-the-job behavior can be assessed. The purpose of this module is to give the outreach worker specific direction as to exactly what is expected of him/her. It is also expected to give supervisors a clear idea of what the job of the outreach worker is so that supervision can be related to assisting outreach workers to develop the capability to perform the job. This presentation should be based upon an available, written job description and should describe the ways in which the job description will be used in evaluating the on-the-job behavior of outreach workers.

Objectives: (1) Outreach workers will describe the behaviors required of them using the functional job description; (2) Outreach workers will describe the ways this job description will be used in evaluating their performance; (3) (Long-term) Outreach workers will evaluate their own performance with the assistance of their CMC supervisor.

Assertive Skills for Outreach Workers - The job of the outreach worker requires an ability to be appropriately assertive in fulfilling the roles of advocate, mediator, broker and conferee. The general goal of this unit is to assess each trainee's level of assertiveness, identify areas or situations in which the development or strengthening of assertive behavior may be required. Although many of the skill objectives of the training component require and develop assertiveness, this unit provides an initial individualized program of assertive training on which other skills will be developed.

Objectives: (1) Trainees will correctly describe the meaning of assertive behavior and its applicability to the job of the outreach workers; (2) Will participate in an individualized assessment of assertiveness and identify needs for further skill development; (3) Will work with trainers and trainees in an ongoing group setting to achieve their own assertive training objectives in simulated settings; (4) (Long-term) Will manifest assertive behavior in the carrying out of their jobs as outreach workers for CMHCs.

Identifying Human Service Consumers - This unit provides a framework for trainees to use in identifying human service consumers. The framework to be used identifies ten problem areas which may negatively affect the functioning of persons. Trainees will examine three aspects of problem areas: (a) Identification of problem area; (b) Consumers level of functioning and (c) The nature of the obstacles to effective functioning.

Objectives: Trainees will utilize a framework for identifying human service problems in case simulations and will correctly identify selected problems, levels of functioning and obstacles to change.

Mental Health and Mental Illness - This instructional unit provides the trainee with a basic understanding of the components of psychological well being and illness. Because trainees will, of necessity, be interacting with professionals who share a general common framework for understanding mental health and mental illness, trainees will need to be familiar with the "perceptual bias" of the mental health professional. But outreach workers will also need to be familiar with common beliefs about mental health and mental illness which may be shared by the client group toward whom they are addressing their efforts. These biases will reflect both the dominant culture but also significantly will be influenced by the cultural underpinnings and values of Indian culture. This instructional unit will therefore concern itself as well with the probable cultural conflict inherent in attempting to understand mental health and mental illness. Differences in the potential ways mental health and illness are viewed from the perspective of the dominant White culture and Indian culture will be explored in some depth, with an identification of the problems this poses for the outreach worker. Attempts to resolve these problems will not be attempted in this instructional unit.

Objectives: (1) Students will describe a selected model of mental health and well being and models of mental illness; (2) Students will contrast Indian and White models of mental health and mental illness and will identify points of similarity and difference; (3) Students will identify the points of conflict between dominant and Indian conceptions of mental health and mental illness.

Common Forms of Mental Health Problems - The purpose of this instructional unit is to provide trainees with an introductory guide to the identification of common mental health problems. In particular, the problems to be identified are (a) suicide; (b) alcoholism; (c) family

dysfunction; (d) psychosis; (e) neurosis. This unit will provide the trainee with a beginning understanding of the concepts described above together with an orientation to the major ways in which these specific problems are typically dealt with in mental health settings from the point of view of four basic models: (a) biological; (b) psychological; (c) the behavioral model; (d) the social model. This instructional unit then discusses examples of problems falling in these areas and provides trainees with an opportunity to identify mental health problems according to these classifications. Additionally, a cultural model for viewing these problems from an Indian perspective will also be identified and differences in perspectives will be discussed with respect to the way in which outreach workers may identify observable problems mentioned above to mental health resources in ways which promote acceptance of the client by the CMHC and at the same time understanding by the mental health professional of the way in which this mental health problem can be understood from an Indian perspective. The goal here is to provide the outreach worker with the ability to communicate with mental health workers in ways both familiar to the mental health worker but also in ways which will promote the shift of perspectives about mental health to a manner more consistent to the cultural needs of the client.

Objectives: (1) Trainees will identify observable mental health problems, given a set of case studies and will state the need for referral to an appropriate resource; (2) Trainees will identify four common CMHC orientations to mental illness as well as Indian cultural orientations to the understanding of the mental health problem; (3) Trainees in a simulated role play will refer clients to mental health resources by communicating

both the problem in terms discernible to mental health workers and in terms of the cultural perspective of the Indian client, expressing the need to take these factors into account.

Indian Alcoholism - This unit identifies the role of alcohol in the etiology and symptomatology of physical, emotional and social problems of the urban Indian. The identification of alcoholism and the use of community-based resources is the focus of the unit.

Objectives: (1) Trainees will define alcoholism and apply this definition while assessing other common problems of human service consumers; (2) Trainees will be able to describe common programs currently used in alcoholism treatment centers used by Indian people; (3) Trainees will refer potential clients to alcoholism treatment programs under simulated conditions.

Positive Coping Skills for Clients and Workers - This module identifies the ways in which clients utilize their own personal capacities for problem solving, relating to others and taking action to deal with personal problems in constructive ways. It provides an explicit model of mental health against which mental health problems can be understood and identified. These positive coping skills can be used as client strengths capable of being further strengthened and utilized in the helping process.

Objectives: (1) Trainees will review the concept of positive coping skills; (2) Will identify such skills in selected case examples; (3) Will state how such skills can be recognized and utilized as part of programs of help giving and in simulated consultative settings will describe this to CMC supervisors.

Barriers to Services for American Indians: Value Conflicts and Institutional Barriers - This unit looks at "pan-Indian values" that have been identified in the literature by both Indian and non-Indian writers.

These traits and their interrelationships have been described as creating conflict for Indians who move to urban areas and attempt to adjust to White middle-class dominated society, finding many of these traits maladaptive. The way in which cultural differences create institutional barriers for receiving services will be explored in detail. Since the barriers either prevent or discourage ethnic minorities or socioeconomic class from utilizing mental health services, the focus of the latter half of this instructional unit will attend to the role of the Indian outreach worker in helping to remove those barriers.

Objectives: (1) Students will describe ten Indian values and the common conflicts that these values produce for urban Indian groups seeking assistance from the human services and particularly mental health services; (2) Students will identify the major institutional barriers to service and describe ways in which they can contribute to the removal of those barriers.

Helping Skills for Outreach Workers - This instructional unit is a skill-building unit designed to increase the capability of outreach workers for responsive and empathic communication with potential clients. The format for this instructional unit is micro-training. The workshop format has been used successfully with Native Americans as well as other minority groups. The skills to be developed are primarily attending or listening skills. The emphasis is placed on hearing the helpee accurately and clearly--and then communicating that hearing or understanding back to the client. The helping skills emphasized in this instructional unit include: (1) Attending behavior; (2) Open invitations to talk and minimal encouragements; (3) Paraphrasing; (4) Reflection of feeling (reflection of feeling will be described as empathic listening and will be evaluated through the use of Robert Carkhuff's empathic training criteria). Basically this criteria insures that adequate minimal

helping skills are present with respect to this dimension; (5) Summarization--the gathering together of several strands of thought from an interview, thus facilitating helpee understanding and action. The process used here will be role playing, simulated client concern.

Objectives: Students will perform the five basic responsive listening skills described above to a criterion level consistent with effective helping.

Functioning of the Mental Health Center - The mental health center is described in terms of the services it provides, the way in which it is organized, and the major factors (contingencies) that affect the functioning of the organization. The purpose is to give trainees a picture of community mental health, the services offered, and the general criteria used in selecting and admitting clients for service. Most importantly, however, the purpose of this instructional unit is to give trainees a realistic idea of the sources of influence that affect the organizational functioning of the CMHC. Trainees need to be aware of these factors in order to develop a realistic idea of what they may hope to accomplish by way of influencing the services that are provided, to insure that their aspiration level for organizational influence bears a relationship to the actual probability of change within that organization. Otherwise, the expectations of the outreach workers may produce early discouragement and disappointment.

Objectives: (1) Trainees will describe the major services offered by the Community Mental Health Center; (2) Trainees will describe the major criteria for admission for service to a CMHC; (3) Trainees, on the basis of an understanding of the factors affecting the CMHC organization, will describe the contributions they may be able to make in influencing the services provided by their CMHC.

Information and Referral - Brokering is an activity which requires the outreach worker to identify the service needs of individuals, see that they have the information they need, and see that their unmet needs are met through the provision of an appropriate resource. For the outreach worker, this requires making available knowledge of community resources and insuring that the person and the appropriate resource come in contact with one another.

Objectives: (1) Trainees will demonstrate through role play the process of determining an individual's unmet needs; (2) Will provide consumers with appropriate information in terms relevant to the person's expressed needs; (3) Will identify five "do's" and five "don'ts" in making referrals to appropriate resources, emphasizing mental health resources; and (4) Will demonstrate the skills of effective referral and follow-up in simulated settings.

Reaching Out to Individuals in Your Community - Part of the brokering role involves reaching out to potential clients in community settings to assist them in meeting unmet needs. Reaching out involves the process of being sensitive to expressed needs, using techniques for gathering information about needs and breaking the ice or introducing the topic of how clients might meet needs which they may have indirectly indicated they possess.

Objectives: (1) Trainees will be able to describe why reaching out or initiating contacts with potential human service consumers is necessary; (2) Will be able to relate the necessity of reaching out to the hard-to-reach agency; (3) Will identify helpful ways of initiating a first contact with an individual or family, given a set of sample situations, elaborating skills learned in the module "Describing Yourself to

Different Groups"; (4) Will identify and describe how to use four techniques of reaching out in their community.

Identifying Community Resource Systems - Trainees will need to be aware of a method for identifying resources in their community settings in order to carry out brokering activities. This module describes the various resource systems found in most communities and provides a checklist for trainees to use as they discover more about the human service resource network in their own local area.

Objectives: (1) Students will review the definition of resource systems; (2) Identify three kinds of resource systems and describe examples of each system; (3) Consider the inadequacies of each resource system; (4) Can describe the means by which they will identify local resources in their own community setting.

Crisis Intervention - It is common for outreach workers to encounter crisis situations in their contacts with human service consumers. The major goals of helping clients in a crisis are to help the person experience the crisis in such a way as to promote a greater degree of behavioral and psychological freedom, to enable the client to experience a significant degree of success at mastering the crisis situation and to identify those elements that are useful in resolving the crisis state.

Obejctives: (1) Trainees will state the meaning of the term "crisis" and describe its progression through common successive stages; (2) Will identify eleven techniques for helping consumers deal successfully with personal crisis; (3) Will utilize selected techniques in helping persons cope with a crisis in simulated situations.

Techniques of Advocating - Advocating means standing up for individuals and being willing to do what is necessary to uphold their rights. While

advocating does not mean making unreasonable demands on human service agencies, it does emphasize protecting and defending the rights of individuals by using recognized legitimate means in their behalf. This instructional module introduces basic skills involved in persuading and applying appropriate kinds of pressure, on behalf of clients, to human service agencies.

Objectives: (1) Trainees will identify three reasons why human service consumers sometimes need advocates; (2) Will identify three factors to be used in deciding whether to be an advocate; (3) Will identify three guidelines for using the advocating technique; (4) Can identify basic components of persuasion; (5) Will practice three different techniques for persuading, using simulations; (6) Will review five helpful hints to use when persuading; (7) Will identify the difference between persuasion and pressuring; (8) Will examine two techniques used in pressuring.

Identifying the Basic Rights of Human Service Consumers - There is a need to recognize that human service consumers should be recognized as having basic rights in obtaining services. Further, it is important to insure that these basic rights are upheld in all human service settings. Currently there is only weak agreement about specific rights and these vary from agency to agency. This module describes the basic rights of consumers in relation to mental health, developmental disabilities, corrections and welfare.

Objectives: (1) Trainees will identify the meaning of the term "right"; (2) Will distinguish the difference between legal rights and human rights; (3) Will identify the rights of consumers in selected settings; (4) Will identify the basic rights of all human service consumers.

Identifying Unmet Community Needs and Taking Action - Mobilizing involves working with community problems or unmet needs and is the activity used to try to do something about these unmet needs. Mobilizing involves the process of either encouraging existing service agencies to work together to deal with an unmet community need or of creating a new resource to meet the need.

Objectives: (1) Trainees will describe what is meant by an "unmet community need" and will apply the concept to selected examples; (2) Will identify five areas of knowledge needed in understanding a community; (3) Will review the meaning of mobilizing; (4) Will identify the basic objectives of mobilizing; (5) Will identify the primary types of community groups that may serve as mechanisms for mobilizing; (6) Will consider five basic steps to follow in mobilizing for change.

Mobilizing in Your Community - The purpose of this module is to identify the skills of structuring and participating in group meetings and the process of helping community groups solve problems.

Objectives: (1) Trainees will distinguish the difference between formal and informal meetings; (2) Will identify and selectively practice the skills of participating and leading group meetings; (3) Will distinguish the different roles which may be played when working with community groups; (4) Will identify six stages of group problem solving.

Learning to Describe Yourself to Different Groups - The purpose of this instructional unit is to provide trainees (via role playing) with specific opportunities for them to describe their roles to mental health workers in the mental health system, formal human service resources in the community, and client groups. It is assumed here that trainees will require initial guided practice in describing their roles sufficiently clearly so

as to initially develop the credibility necessary to the accomplishment of their goal. This exercise will provide trainees with the ability to structure expectations about their function with other significant groups.

Objectives: Trainees will in simulated circumstances clearly describe their functions to other mental health workers, representatives of other community human service organizations, and clients. These descriptions will be evaluated according to clarity, accuracy and the extent to which the description is likely to enable the trainee to accomplish his/her specific task with that person or group.

How to Get Something Done Each Day/Week/Month - The purpose of this instructional unit is to show trainees how to usefully manage their time by setting performance objectives, prioritizing them, and identifying the specific tasks necessary to the accomplishment of the objective. Trainees will be taught how to keep a daily/weekly/monthly log of objectives and activities. This instructional unit is based on the assumption that trainees will largely provide much of their own structure, and thus must have a means for task accomplishment that is not directly based on specific assignments given to them by others. This can also be seen as one aspect of a data collection system for evaluating the performance of the outreach worker under a given set of circumstances. Trainees will be taught how to use the content of their log for self evaluation and improvement of their functioning.

Objectives: Trainees will demonstrate knowledge of the performance by objective system by accurately logging a set of objectives and tasks designed to accomplish those objectives during the course of the training program. These logs will be evaluated and returned to the trainee with feedback.

The Meaning and Components of Consulting - Consulting is the process of obtaining and providing advice or information to help solve a problem. Often this problem is related to a client although it may relate to the functioning of the outreach worker, supervisor, community mental health center or other organization. It may involve problems in the functioning of outreach workers. This module introduces the concept of consulting.

Objectives: (1) Trainees will review the meaning of consulting and will discuss it with their CMHC supervisor; (2) Will identify three elements of the consulting process; (3) Will examine three common features of all consulting activities.

Receiving Help from a Consultant - The purpose of this module is to learn about the process of receiving help from other workers and your supervisor for help with client related problems. This unit will assist trainees in deciding whether another's help is necessary, and if it is what steps should be taken after receiving assistance.

Objectives: (1) Trainees will consider seven questions that will help you in determining whether you need to consult with another worker; (2) Will state five ways the trainee can help the consultant help him; (3) Will identify the steps to be taken after receiving help from another worker.

Acting as a Consultant - This module introduces some ways in which the outreach worker can give help to other human service workers with consumer or client-related problems.

Objectives: (1) Trainees will examine three questions which will help them determine whether they can be of assistance to another worker with a client related problem; (2) Will identify three ways to view the consultative relationship with another worker or supervisor; (3) In a

simulation will practice four skills which can be used in establishing and maintaining a good consulting relationship with another worker; (4) Identify six guidelines to follow in consulting with another worker.

Participating in a Case Conference - A case conference involves meeting with other workers and supervisors in an agency setting to discuss problems and/or service plans regarding consumers. Its goal is to share pertinent information that can be used in problem solving.

Objectives: (1) Trainees will identify the major purpose of the case conference; (2) Will review two main types of case conference; (3) Will state five topics which are important to include in the summary of a problem case; (4) Will consider four steps usually followed in a case conference.

Using Supervision - The purpose of this module is to help trainees use supervision effectively. To do this, the trainee must co-participate in structuring supervisory sessions, understand the reason for supervision and know what to expect from the supervisor.

Objectives: (1) Trainees will examine the meaning of supervision; (2) Review four primary tasks of the supervisor; (3) Identify six expectations of supervisors; (4) Examine the primary elements of the communication process; (5) Review the basic methods of communication; (6) Identify and explain five common blocks to effective communication; (7) Identify and explain five bridges to understanding and improving communication.

Skills of Effective Supervision - This module is designed both for supervisors and trainees, but is directed primarily for supervisors. Its purpose is to describe the functions and duties of the supervisor and to establish criteria by which the activities of the supervisor can be evaluated by himself and others.

Objectives: (1) Supervisors and trainees will identify the four purposes of supervision; (2) Will describe a method the supervisor can use to carry out each of his/her four duties; (3) Will be able to explain what is meant by a supervisor "bringing out the best in people"; (4) Will review five guidelines that are helpful in fulfilling supervisory responsibilities.

Retrospective Follow-up Study

(Task 7, Sub-task A, Evaluation task 1)

The goal of the Community Support Project is to develop a comprehensive array of community-based mental health services for the chronically mentally ill person. It is useful for this purpose to determine, historically, what sort of community-based services have been offered, what kind of ex-patient has utilized these services, what kind of ex-patient is likely to return to the hospital, and whether or not these services are a factor in preventing his rehospitalization.

Toward this end, data were collected on a group of Warm Springs State Hospital ex-patients. The group consisted of all patients discharged from Warm Springs to mental health region III during the years 1976, 1977, and 1978, with a diagnosis of psychosis. These criteria were met by 120 persons in all, out of a total of 262 discharged to region III. Hospital records were then consulted to determine the following background information for each ex-patient: sex, race, age at discharge, diagnosis, duration of most recent hospitalization, and number of hospitalizations during the four years prior to discharge.

Follow-up data were collected for each ex-patient for one year following the date of discharge. Mental health center records were consulted to determine what community-based services, if any, were received during the follow-up period, and the duration of these services. Mental health center records allowed determination of this information for the following service modes: CMHC client status, partial hospitalization, residential care, and inpatient care. To determine recidivism to Warm Springs during the follow-up year, hospital attendance records were consulted.

Taken as a whole, the group of 120 ex-patients was found to consist of 69 males (57.5%) and 51 females (42.5%). Whites represented 96.7% of the group, Indians 2.5%, and blacks less than one per cent. The average age of the group was 47.5 years, and ranged from 15 to 85 years. At discharge, 78.3% of the group were given a diagnosis of schizophrenia, 10.8% were diagnosed as having an affective psychosis, and the remaining 10.9% had some other form of psychosis.

The average ex-patient had spent 7.3 years in the hospital prior to discharge, but this mean represents extremely variable data: the maximum period was 49.2 years, and the minimum was 6 days. Twenty-nine of the ex-patients, or 24.2% returned to the hospital at least once during the follow-up year.

Table 1 reports the number of ex-patients having various kinds of contact with the community mental health center, and the average duration of these contacts during the follow-up period.

TABLE 1

Type of Contact with CMHC	Number of ex-patients	% of total	Average number of mont of CMHC contact, first year after discharge
CMHC client status	57	47.5	9.2
partial hospitalization	29	24.2	7.2
residential care	24	20.0	7.9
inpatient care	6	5.0	.5

It should be noted that all clients who participate in a CMHC service are enrolle as CMHC clients. It is possible for a person to be a CMHC client without participating in partial hospitalization, residential care, or inpatient care, however. This could occur if the person were receiving outpatient or emergency care only.

Of the 120 discharged patients, slightly less than half had contact with the CMHC during the follow-up period. About a quarter of the patients participated in partial hospitalization, and about one-fifth were involved in residentia care. There was a great deal of overlap between these latter two services; 79% of the ex-patients who received partial care also received residential care. Data were not available to determine what proportions of the 63 non-contactors refused services, were not offered services, or were not deemed to need services. However, Table 2 below, which reports the characteristics of the 57 contactors and the 63 non-contactors, gives an idea of some of the differences between the two groups.

TABLE 2

Variable		Contact w/CMHC (N=57)	No Contact w/CM (N=63)
sex	male	28 (49.1%)	41 (65.1%)
	female	29 (50.9%)	22 (34.9%)
race	white	55 (96.5%)	61 (96.8%)
	black	0 (0%)	1 (1.6%)
	Indian	2 (3.5%)	1 (1.6%)
diagnosis at discharge	schizophrenia	49 (86.0%)	45 (71.4%)
	affective psychosis	4 (7.0%)	9 (14.3%)
	other psychosis	4 (7.0%)	9 (14.3%)
mean length of most recent hospitalization		118.5 months	60.7 months
mean age		48.5 years	46.6 years
number of hospitalizations, during the 4 years prior to discharge		1.1	1.4

One of the most striking findings from this table is the much lower proportion of males among those contacting the mental health center, as compared to those who did not contact the mental health center. Although males predominated in the initial group of 120 discharged patients (57.5%), apparently some aspect of the process of becoming a CMHC client favors females. No such bias was observed in the case of race. With regard to diagnosis, the proportion of schizophrenics among those contacting the CMHC's was somewhat higher than among those not in contact.

Another noteworthy finding is the fact that ex-patients in contact had a prior hospitalization almost twice as long as those not in contact (approximately 10 years versus 5 years). This tends to indicate that the selection process is favoring the more chronic, institutionalized ex-patient over the less chronic one.

The next table explores the differences between ex-patients who returned to the hospital during the one-year follow-up period and those who remained in the community.

TABLE 3

Variable		recidivists (N=29)	non-recidivists (N=91)
sex	male	20 (69.0%)	49 (53.8%)
	female	9 (31.0%)	42 (46.2%)
race	white	28 (96.6%)	88 (96.7%)
	black	0 (0%)	1 (1.1%)
	Indian	1 (3.4%)	2 (2.2%)
diagnosis at discharge	schizophrenia	22 (75.9%)	72 (79.1%)
	affective psychosis	5 (17.2%)	8 (8.8%)
	other psychosis	2 (6.9%)	11 (12.1%)
mean length of most recent hospitalization		47.5 months	101.1 months
mean age		35.4 years	51.3 years
number of hospitalizations, during the four years prior to discharge		1.8	1.1
CMHC client	yes	10 (34.5%)	47 (51.6%)
	no	19 (65.5%)	44 (48.4%)
partial hospitalization client	yes	5 (17.2%)	24 (26.4%)
	no	24 (82.8%)	67 (73.6%)

TABLE 3 (continued)

Variable		recidivists (N=29)	non-recidivi (N=91)
residential care client	yes	5 (17.2%)	20 (22.0%
	no	24 (82.8%)	71 (78.0%
inpatient client	yes	4 (13.8%)	2 (2.2%
	no	25 (86.2%)	89 (97.8%

Again there is a striking sex difference; the proportion of males is much higher among recidivists than among nonrecidivists. There is also a large age difference between the two groups, with the average recidivist being 35.4 years old whereas the average non-recidivist is 51.3 years.

There are also substantial differences between the two groups with regards to hospital history. Prior to the discharge which preceded the follow-up period, the average recidivist spent about 4 years in the hospital, whereas the average nonrecidivist spent about 8 years in the hospital. Also, the average recidivist was hospitalized 1.8 times during the preceding 4 years, while the average non-recidivist was hospitalized only 1.1 times. These two findings suggest that recidivists are more likely to be acute, short-stay patients.

It is also of interest to compare the two groups in terms of the community servic received during the follow-up period. Non-recidivists were more likely to have been CMHC clients and to have received partial hospitalization or residential services than were recidivists. On the other hand, non-recidivists were less likely to have received inpatient care than were recidivists.

The above findings implicate both background factors (age and hospital history) and community services in recidivism. To obtain a clearer idea of the role of community services in reducing recidivism, the follow-up period was divided into two six-month intervals. Community services received during the first six months were then related to recidivism to Warm Springs during the second six months. The table below reports the number of clients falling into each of the following four categories: 1) did not receive community services (during first six months) and did not return to Warm Springs (during second six months), 2) did receive community services and did not return to Warm Springs, 3) did not receive community services and did return to Warm Springs, and 4) did receive community services and did return to Warm Springs.

TABLE 4

	not returned to WSSH, during second six months	returned to WSSH during second six mont
	(1)	(3)
no community services during first six months	48	21
	(2)	(4)
community services during first six months	46	5

Of the 120 expatients, a total of 26 returned to the state hospital during the second six-months period. If there were no relationship between community services and recidivism, then categories (1) and (2) should contain approximately equal numbers of clients, and categories (3) and (4) should contain approximately equal numbers. If there is a relationship of a preventative nature, then category (1) should tend to be smaller than category (2), and category (3) should tend to be larger than category (4). Table 4 partly bears out this prediction, in that very few of the recidivists had received prior community services - only 19% of the 26 recidivists had received community services. A chi-square test indicates that the relationship between prior services and later recidivism is a significant one (chi-square =7.35, d.f. = 1, $p < .01$).

As shown earlier in Table 3, the three background factors of age, number of hospitalizations and duration of prior hospitalization also have a significant relationship to recidivism. Is the role of community services in preventing recidivism largely due to these background variables, rather than to the services themselves? One way to approach this question is to examine the correlation between amount of community service received during the first six months with length of rehospitalization during the second six months, while controlling for the correlations of the background variables.

First, the simple correlation between community service (number of days spent as a CMHC client, plus number of days spent in each of the modes of parital hospitalization and residential care) and rehospitalization time was calculated. As expected, this correlation was negative and large ($r = .153$, d.f. = 118, $p < .047$, one-tailed). That is, the more days spent receiving community service during the first six months, the fewer days spent in hospital during the second six months.

What happens to this relationship when the effects of the three background variables are controlled for? The third-order partial correlation of community service time with rehospitalization time, controlling for the effects of age, number of hospitalizations and duration of prior hospitalization, is nearly as large as the simple correlation ($r = -.132$, d.f. = 115, $p < .078$). Therefore, community support services appear to have a negative impact upon recidivism even when these three background variables, which are also related to recidivism, are controlled for.

The data discussed in the preceding pages are more suggestive than conclusive. In the absence of a controlled study it is impossible to pinpoint the precise impact of community support services upon recidivism. Another difficulty stems from the incomplete nature of the historical records from which the data were obtained. Only certain basic elements of community support service were available: CMHC client status, partial hospitalization attendance, residential facility attendance, and inpatient attendance. The many other important community support services that clients may have received were not recoverable. Additionally, client service at nursing homes or from private providers was unknown.

With these limitations in mind, it can be said that several important backgrou factors have been shown to be related to whether or not an ex-patient appears at the CMHC, and also to be related to recidivism. Amount of community-based service also is related to recidivism, and this relationship is independent of several of the important background factors.

Report on Recidivism at Warm Springs State Hospital

(Task 7, Sub-task B)

Evaluation Report 03: Recidivism at Warm Springs State Hospital

Recidivism at Montana's state psychiatric hospital has, until recently, been rather difficult to determine, due to the lack of an automated data base prior to mid-1978. Patient data from July, 1978 to the present is being stored in a computer, but prior to this date the only source of data on patient characteristics, admissions and discharges is a set of punched cards maintained at the hospital. In order to estimate recidivism rates over a period of several years, the punched cards were copied onto magnetic tapes, which were then examined with data analysis programs available at the Department of Administration.

Method. A list of all patients discharged during 1976 was obtained from the magnetic tapes. Of the 816 separate individuals identified as having been discharged during 1976, 100 or 12.3% were randomly selected. For these 100 individuals, admission dates and discharge dates were obtained for the years 1976, 1977, 1978 and 1979. Background data on patient characteristics were also recovered from the tapes for this sample of individuals.

Patient characteristics. Fifty-eight per cent of the sample was male, and 94 per cent were white (the remaining 6 per cent were Native Americans). The average age of the sample was 56.7 years; 65 per cent of the sample were 50 years old or older, while only 15 per cent were younger than 30. Age calculations were based upon the date of first discharge in 1976. Also recorded at date of first discharge in 1976 were marital status, commitment type, diagnosis and region of residence. Frequency distributions for these variables are reported in the tables below.

Marital status	per cent
Single	44
Married	20
Divorced	15
Separated	6
Widowed	6
Annulled	1
Unknown	8

Type of commitment	per cent
Voluntary	51
Involuntary	4
Court order	9
Court-ordered evaluation	7
Other	19

Diagnosis	per cent
Psychosis	54
Personality disorder	6
Neurosis	2
MR	10
OBS	11
Other	10
Unknown	7

Region of residence	per cent
I	9
II	23
III	9
IV	45
V	14

The great majority of the clients are either single or formerly married (72 per cent). Over half (51 per cent) were committed voluntarily prior to their first discharge in 1976. Fifty-four per cent of the sample were diagnosed as psychotic, with the remainder scattered across a variety of categories. As expected, more of the patients had residence in Region IV than in any other region.

Recidivism. The table below reports the number of times a patient returned to the hospital between his first discharge in 1976 and the end of 1979. The great majority, 78 per cent, did not return at all during that time. Of those who did return, the majority returned only once. From first discharge in 1976 until the end of 1979, the average patient in the sample spent 117.4 days back in the hospital.

Number of times returned to hospital	per cent
0	78
1	14
2	3
3	2
4	3

Recidivism rates are typically expressed as the proportion of released persons who have relapsed by various periods of time. The accompanying graph shows the proportion of patients in the sample who have returned at least once to the hospital as a function of the number of months since discharge (the line represented by 0-0-). It can be seen that 8 per cent of the sample had returned to the hospital at least once six months after discharge, 14 per cent by one year after discharge, 21 per cent by two years after discharge, and 22 per cent by three years after discharge. These data show that virtually all relapses that occurred had occurred by 18 months after discharge.

It should be emphasized that these figures include patients who have returned and then left the hospital again during the period after discharge. The other line of the graph (represented by X-X-) indicates the proportion of the patient sample who are actually back in the hospital for given intervals of time after discharge. It is interesting to note that this proportion varies between 7 and 12 percent and does not increase with increasing time after discharge. This indicates that most of those who did return to the hospital during the time period observed were able to leave the hospital again.

RECIDIVISM AT WARM SPRINGS STATE HOSPITAL

Instrument for Longitudinal Follow-along Study

(Task 7, Sub-task A, Evaluation task 1)

Longitudinal Follow-along Instrument

(Adapted from an instrument developed

by the Iowa Mental Health Authority)

COMMUNITY ADJUSTMENT INDEX

RATING SCALES

A. INDEPENDENT LIVING SKILLS

Level 1 ☐ — Self-care and self-maintenance in all aspects, including long-range provisions for the future of self and perhaps family (i.e., insurance, credit, etc.)

Level 2 ☐ — Self-care and self-maintenance on an immediate basis. Able to handle savings and checking accounts, income tax. May use community resources. Partial dependence on external resources for long-range planning.

Level 3 ☐ — Self-care and self-maintenance; handles own money for immediate situation and knows and practices basics of physical care and safety. Long-range planning not apparent. Avoids common dangers.

Level 4 ☐ — Assumes responsibility for self-care and some self-maintenance functions, like choosing own clothes and spending money on some simple things. May not always avoid common dangers.

Level 5 ☐ — Performs some self-care functions but may sometimes need reminding. May need supervision for clothing choices, caring for belongings, keeping to a schedule, and avoiding dangers.

Level 6 ☐ — Needs help in most areas of self-care; i.e., toilet n cleanliness, grooming, eating. Does not recognize or avoid common dangers. Does not keep to own schedule o care for belongings.

Level 0 ☐ — Information insufficient for rating.

B. INTERPERSONAL RELATIONS

Level 1 ☐ Interaction with others appropriate. Demonstrates concern for others by community or other constructive/ helping activity.

Level 2 ☐ Interaction with others generally appropriate. Lives independently alone, or with family or group of own choosing. Assumes partial responsibility for living group, but does not demonstrate interest or concern beyond that.

Level 3 ☐ Lives independently. Interactions with some others appropriate but with some others may be mildly inappropriate but is not significantly disruptive.

Level 4 ☐ Social interactions with some others usually appropriate and tolerated; with others often inappropriate and disruptive but usually tolerated.

Level 5 ☐ Social interactions with some others may be appropriate; he/she is tolerated, sometimes with difficulty. However, may participate with supervision in structured activities with others. Social interactions with some others often inappropriate and not tolerated.

Level 6 ☐ Does not interact appropriately with either familiar or unfamiliar others. Others, even those most familiar with him/her, do not tolerate his/her behavior.

Level 0 ☐ Information insufficient for rating.

C. COPING WITH STRESS

Level 1 ☐ Remains stable through most of life crises; may become mildly upset, but not dysfunctional, with major crisis or accumulation of crises.

Level 2 ☐ Symptom recurrence under major change or some major life stress.

Level 3 ☐ Symptoms are highly likely to recur under mild to moderate stress. Mild support necessary to control temporary disruptive or regressed behavior following major situational changes or light stress.

Level 4 ☐ With support is able to remain relatively stable under changes in immediate situation; temporary intervention required to control disruptive or regressed behavior following stress.

Level 5 ☐ Remains relatively stable when environment, including schedule, has only minor changes. Major change and other stress may lead to outbursts or other disruptive behavior that requires continued intervention.

Level 6 ☐ May respond to change or other stress with physical att or even more regressed behavior. Maintaining behavior depends on stability of environment and consistency of routine. Maintaining behavior depends on immediate gratification of his/her needs.

Level 0 ☐ Information insufficient for rating.

D. GENERAL ADJUSTMENT

Level 1 ☐	Functioning well in all areas. No evidence of need for support system.
Level 2 ☐	Functioning well in all areas with minimal indication of stress. Individual needs suggest advisability of occasional support.
Level 3 ☐	Independent functioning socially and vocationally. Occasional evidence of stress necessitates easy availability of supportive or therapeutic services.
Level 4 ☐	At least semi-independent in most areas. Supervision, sheltered environment, or outpatient services necessary for functioning on this level.
Level 5 ☐	Minimal functioning in most areas. Some kind of structured living situation necessary.
Level 6 ☐	Dysfunctional in most or all areas. Almost totally dependent on others for support, protection, self-care.
Level 0 ☐	Information insufficient for rating.

E. Service Utilization Questionnaire

Instructions: Please indicate which of the services below this client has received during the past month. Fill in each box with one of the following codes:

NI - no information

NN - service not needed

NA - service needed, but not available

NR - service needed, but refused

R - service received

☐ A. assistance in applying for benefits from other service agencies

☐ B. other assistance in dealing with other service agencies or legal agencies.

☐ C. training in living skills (for example; cooking, doing laundry, shopping)

☐ D. training in social skills (for example; recreation with others, meeting people, conversational skills, making friends)

☐ E. training in work skills (how to find a job, interview for it, and how to keep it)

☐ F. presence in a sheltered work setting (did your agency assist in arranging this placement? Check one:

yes ☐ no ☐ don't know ☐)

☐ G. presence in a residential living (non-hospital) setting

(facility 1 - hours per week supervised _____

facility 2 - hours per week supervised _____)

☐ H. presence in a competitive employment setting

(did your agency assist in arranging this placement? Check one:

yes ☐ no ☐ don't know ☐)

☐ I. psychiatric inpatient care (including inpatient emergency care)

- [ ] J. state psychiatric hospital care
- [ ] K. outpatient emergency care
- [ ] L. medical or dental care (of a non-psychiatric nature)
- [ ] M. assistance to the client's family, neighbors, employer, or friends
- [ ] N. assistance to client in processing a grievance against your agency
- [ ] O. outpatient (non-emergency) care

List of Indicators used in the Component

Assessment Instrument

(Task 7, Sub-task A, Evaluation Task 2)

I. Identification and Outreach

	Aspect	Indicator	Source
A.	Discharge notification	1-(Number of WSSH discharges to region without prior notice ÷ total discharges), last quarter	CSP staff, WSSH database
B.	WSSH prescreening	Number of WSSH admissions screened prior to admission ÷ total WSSH admissions, last quarter	WSSH database
C.	CMHC followup of WSSH discharges	Number discharged from WSSH who are receiving CMHC services ÷ total number discharged to region, last quarter	WSSH & CMHC databases
D.	Inappropriate admissions	Number of appropriate admissions ÷ total WSSH admissions, last quarter	WSSH database
E.	Relations with nursing homes	For each nursing home: regular, on-going relationship with CMHC staff? Y or N	CSP staff
F.	Community outreach	For previous year: 1)one or more attempts to locate new groups of chronically mentally ill? Y or N 2) one or more attempts to reach each significant minority group? Y or N	CSP staff
G.	CSP screening	Are new aftercare clients routinely screened for CSP eligibility? Y or N	CSP staff
H.	Discharge-ready patients	Number of discharge-ready patients at WSSH ÷ total patients (for a given region)	Social workers at WSSH

II. Crisis Assistance

	Aspect	Indicator	Source
A.	24-hour telephone availability	For each satellite: hours per day telephone assistance is available (0 to 24)	CSP staff
	Crisis visit capability	For each satellite: hours per day staff are available to visit crisis site (0 to 24)	CSP staff

Crisis Assistance (continued)

	Aspect	Indicator	Source
C.	Short-term crisis beds	Number of crisis beds available ÷ number needed	CSP staff, case manag
D.	Crisis phone number publicity	For each satellite: is crisis phone number publicized in 1) yellow pages? Y or N 2) newspaper? Y or N - No. of times per year 3) radio? Y or N - No. of times per year 4) Other _____? Y or N	CSP staff
E.	Training of community care-givers	For past year: one or more efforts by CMHC staff to train community care-givers in crisis management? Y or N	CSP staff
F.	Crisis log book	Crisis log book maintained? Y or N	CSP staff

III. Benefits Assistance

	Aspect	Indicator	Source
A.	Written agreements with benefit agencies	Number of written agreements ÷ by number of benefit agencies identified	CSP staff
B.	Eligibility screening	For each type of benefit: number of clients screened for eligibility ÷ by number who may be eligible	Case manage
C.	Application success	Number of successful applications ÷ by total number of applications	Case manage

IV. Psychosocial Rehabilitation

	Aspect	Indicator	Source
A.	Work evaluations	Number of clients work evaluated ÷ by number unemployed but employable	Case manage
B.	Daytreatment placements	Number of clients attending day-treatment two or more times per week ÷ number needing daytreatment (excluding supportive clients)	Case manage

Psychosocial Rehabilitation (continued)

	Aspect	Indicator	Source
C.	Employment training	Number receiving employment training ÷ number needing it (excluding supportive clients)	Case managers
D.	Employer outreach	Number of employers approached on behalf of ready-to-work clients ÷ number of ready-to-work clients	Case managers
E.	Competitive employment placements	Number in competitive employment settings ÷ number needing competitive employment	Case managers
F.	Residential capacity	Number of residential beds ÷ number needed	Case managers
G.	Socialization activities	Number attending socialization activities ÷ by number needing them	Case managers
H.	Residential facility criteria	For each residence: are there formal entry/exit criteria? Y or N	CSP staff
I.	Sheltered workshop placements	Number in sheltered workshop setting ÷ number needing sheltered workshop setting	Case managers

V. Supportive Services of Indefinite Duration

	Aspect	Indicator	Source
A.	Supportive work placements	Number of indefinite work placements ÷ number needed	Case managers
B.	Supportive daytreatment placements	Number of indefinite daytreatment placements ÷ number needed	Case managers
C.	Supportive residential placements	Number of indefinite residential placements ÷ number needed	Case managers

VI. Medical and Dental Care

	Aspect	Indicator	Source
A.	Medical care	Number receiving attention for a medical problem ÷ number needing attention	Case managers

Medical and Dental Care (continued)

	Aspect	Indicator	Source
B.	Dental care	Number receiving attention for a dental problem ÷ number needing attention	Case mana
C.	Medication checks	Number receiving regular medication checks ÷ number receiving medication	Client re
D.	Medical exams	Number of clients receiving at least one medical exam in past year ÷ number of clients	Client re
E.	Dental exams	Number of clients receiving at least one dental exam in past year ÷ number of clients	Client re
F.	Physical rehabilitation	Number of clients receiving physical rehabilitation ÷ number needing it	Case mana

VII. Assistance to Families and Community

	Aspect	Indicator	Source
A.	Case manager contact with families	Number of families contacted ÷ Number of clients with families	Case mana
B.	Case manager contact with landlords	Number of landlords contacted ÷ Number of clients with landlords	Case mana
C.	Case manager contact with employers	Number of employers contacted ÷ Number of clients with employers	Case mana
D.	Case manager contact with legal system	Number of clients legal system contacted on behalf of ÷ number of clients involved in legal system	Case mana

VIII. Involvement of Concerned Community Members

	Aspect	Indicator	Source
A.	Client advocacy	Client advocate group in existence? Y or N	CSP staff
B.	Citizen/relative advocacy	Citizen/relative advocacy group in existence? Y or N	CSP staff
C.	Citizen/relative discussion group	Citizen/relative discussion group in existence? Y or N If Y: CMHC-connected? Y or N	CSP staff

IX. Protection of Client Rights

	Aspect	Indicator	Source
A.	Education of clients regarding their rights	Upon intake to CSP, are clients informed of their rights and how to assert them? Y or N	CSP staff
B.	Written summary	Are clients given a written summary of the grievance procedure? Y or N	CSP staff
C.	Formal written procedure for grievance-processing	1) Procedure in existence? 2) Procedure posted?	CSP staff
D.	"Sign-off? mechanism	Do clients acknowledge in writing that they understand their rights? Y or N	CSP staff

X. Case Management

	Aspect	Indicator	Source
A.	Agreements/contracts with CSP - relevant agencies	Number of agreements/contracts ÷ number of CSP - relevant agencies	CSP staff
B.	Identification of CSP-relevant agencies	Has a list of CSP-relevant agencies been prepared? Y or N	CSP staff
C.	Client to case manager ratio	Number of case managers ÷ number of CSP clients	CSP staff
D.	Number of volunteer case managers	Number of volunteer case managers ÷ number needed	CSP staff
E.	Formal training	Formal procedure for training case managers in place? Y or N	CSP staff
F.	Clients without case managers	1-(Number of clients without case managers ÷ total number of CSP clients)	CSP staff
G.	Treatment plans	Number of clients with treatment plans ÷ total number of CSP clients	Client records
H.	Case staffings	Number of clients receiving case staffings last year ÷ total number of CSP clients	Client records

Report on Chronically Mentally Ill Clients on CMHC Caseloads

(Task 7, Sub-task B)

The first step in developing a successful community-based program for the chronically mentally ill (CMI) is to identify this population and its important characteristics. Toward this end, the Community Support Office at NIMH has advocated that each Community Support Project core service agency use a checklist of criteria for identifying the chronically mentally ill clients on its caseload. This checklist was used originally in the state of Georgia, and consists of two sets of yes-or-no items relating to history of prior hospitalizations, lack of occupational and living skills, and lack of social supports (see appendix). Those clients scoring "yes" on one or more items of the first set and "yes" on three or more items of the second set are classified as chronically mentally ill and therefore in need of community support services.

The most recent Department of Institutions - CMHC contracts have required all five Montana CMHCs, whether currently participating in CSP or not, to screen their caseloads using the checklist. In addition to reporting numbers of chronically mentally ill clients identified, each center also reported information on the county of residence, sex, age, diagnosis, satellite where treated, race, and psychiatric history of these clients.

The table below reports the number of clients identified as chronically mentally ill in each of the five mental health regions. Also included for comparative purposes are 1978 general population estimates and CMI client-to-population ratios.

Region	Number of clients identified as CMI	Region population (1978 estimate)	Ratio of CMI to population, %
I	116	99,100	.117%
II	249	153,100	.163%
III	434	157,700	.275%
IV	650	186,300	.349%
V	120	188,500	.064%
TOTAL	1,569	784,700	.200%

The figure for Region III includes an estimated 195 CMI residents of Center for the Aged, and the figure for Region IV includes an estimated 250 CMI residents at Warm Springs State Hospital. (More precise figures for WSSH will be available soon). Relative to the general population, these two regions have the highest concentration of CMI clients, due to the institutions located there.

NIMH has reported a nationwide estimate of .66% of the population as having chronic mental illness. If it is assumed that this nationwide estimate is applicable to Montana, then by subtraction the following estimate of unidentified chronically mentally ill persons is obtained for the state: 3,610. Although there is little question that substantial numbers of unidentified CMI exist in Montana, it is unlikely that this many could remain unidentified for long. Therefore it is reasonable to assume this figure to be somewhat inflated.

The tables below present some demographic data for the 1,124 CMI clients identified on the CMHC caseloads:

Sex			Age		
Male	487	(43%)	0-17	15	(1%)
Female	637	(57%)	18-34	374	(33%)
			35-49	281	(25%)
			50-64	303	(27%)
			65+	151	(13%)

Diagnosis			Race		
Affective psychosis	112	(10%)	White	1067	(95%)
			Native Amer.	44	(4%)
Schizophrenia	584	(52%)	Hispanic	8	(1%)
O.B.S.	89	(8%)	Black	0	(0%)
Other	338	(30%)	Other	5	(0%)

Several of the above results are noteworthy: 1) there are appreciably more female: than males among the identified CMI client 2) a wide range of ages are represente(with no one age group predominating (but this may change, as increasing numbers of young CMI clients have been reported) 3) slightly more than half of these clients carry a diagnosis of schizophrenia and 4) the proportions of white and Native Amer can CMI clients resemble their approximate proportions in the general population.

Also of interest is the fact that 535, or only 48% of these clients were reported as having prior hospitalization at W.S.S.H. Apparently a large proportion of the identified clients have qualified for CMI status by virtue of inpatient experience at places other than W.S.S.H.

The next table casts some light on the distribution of identified CMI clients according to their county of residence. For each region, the proportion of clients who reside in the counties where the majority of community support services are concentrated is compared to the proportion of the regions population residing in those counties.

Region	CMI clients	Population (1978 e:
I. Custer, Valley, Dawson counties	95	36,700
all counties in catchment area	116	99,100
proportion	82%	37%
II. Cascade county	199	86,400
all counties in catchment area	249	153,100
proportion	80%	53%
III. Yellowstone county	196	104,000
all counties in catchment area	239	157,700
proportion	82%	66%

IV.	Lewis & Clark, Silver Bow counties	275	80,800
	all counties in catchment area	400	186,300
	proportion	69%	43%
V.	Flathead, Missoula counties	84	119,700
	all counties in catchment area	120	188,500
	proportion	70%	64%

In general, it would seem that the counties where the most extensive community support services are located produce a disproportionately large fraction of identified CMI clients. This may be due as much to migration of clients needing long-term services to the sites of those services as to more active identification and outreach at those sites.

As stated previously, the estimate of unidentified CMI individuals seems inflated, and should be taken with a grain of salt. However, numbers of unidentified CMI surely exist in each of the five regions, and the CMHCs should vigorously pursue ways of finding and reaching out to them.

COMMUNITY SUPPORT PROGRAM

Identification and Needs Assessment

Name _____ Date _____

Address _____ Case # _____

_____ County _____

_____ Case Manager _____

A. Mental Disability (Must meet at least one criterion)

The severe or persistent emotional disorder has resulted in:

_____ two or more hospital admissions within a 12-month period

_____ a single episode of hospitalization since 1973 of at least one-year duration

_____ patient has been followed with medication only for at least one year

_____ patient has been enrolled in Day Care or has been receiving supportive living services for a six-month period

_____ patient has been a high user of unscheduled contact with the mental health system for more than six months

B. Impaired Role Functioning In The Natural Environment (must meet at least three criteria)

In addition, because of the extent of their mental disability, these individual typically:

_____ are unemployed with markedly limited job skills and/or a poor work history

_____ are employed in a sheltered setting

_____ are unable to perform basic household management tasks without assistance

_____ exhibit inappropriate social behavior which results in rejection by the community and requests for intervention by the mental health or judicial/legal system

_____ are unable to procure appropriate public support services without assistance

_____ require public financial assistance for out-of-hospital maintenance (SSI, general assistance, supportive living funds, etc.)

_____ severely lack social support systems in the natural environment (no close friends, live alone, no group affiliations, highly transient)

_____ are placed in a nursing home setting because of financial considerations and/or because a less restrictive suitable environment is not currently available

_____ are non-compliant recipients of mental health services when a clear need for such is evident.

The chronically mentally ill caseload of Warm Springs has now been identified. Out of 317 patients in residence as of January 1, 1980, (not including children or short-term forensic patients), 215 or 67.8% were judged to be chronically mentally ill usin the Georgia definition. Substituting the figure of 215 for the previous estimate of 250, the following estimates of identified chronically mentally ill by region were obtained:

Region	Number of clients identified as CMI	Region population (1978 estimate)	Ratio of CMI to population, %
I	116	99,100	.117%
II	249	153,100	.163%
III	434	157,700	.275%
IV	615 (was 650)	186,300	.300% (was .349%)
V	120	188,500	.064%
TOTAL	1,534 (was 1,569)	784,700	.195% (was .200%)

The next tables give breakdowns of the Warm Springs State Hospital chronically mentally ill population by region, sex, age, race and diagnosis.

Region		
I	31	(14.4%)
II	32	(14.9%)
III	50	(23.3%)
IV	66	(30.7%)
V	36	(16.7%)
TOTAL	215	

Sex		
Male	143	(66.5%)
Female	72	(33.5%)
TOTAL	215	

Age		
18-35	75	(34.9%)
36-49	41	(19.1%)
50-65	60	(27.9%)
65+	39	(18.1%)
TOTAL	215	

Race		
Anglo	197	(91.6%)
Hispanic	1	(0.5%)
Indian	14	(6.5%)
Black	2	(0.9%)
Other	1	(0.5%)
TOTAL	215	

Diagnosis

Schizophrenia	119	(55.3%)
Affective psychosis	14	(65 %)
O.B.S.	34	(15.8%)
Other	48	(22.3%)
TOTAL	215	

The Department of Social and Rehabilitation Services has estimated that, of a total of 15,111 recipients of either SSI or SSDI, approximately 4.6% are receiving this aid due to a mental-illness related disability. This gives a numerical estimate of 695 mentally disabled recipients. How many of these are known to the mental health centers is at present unknown.

Assessing Community Support Program

Implementation in Montana

(Community Support Service Journal, Springs, 1980)

(Task 7, Sub-task B)

ssessing Community Support rogram Implementation in ontana

d Drachman, Ph.D.
ram Evaluator, State of Montana
artment of Institutions

n January 10, 1978, Montana was rded a contract to initiate a Com- ity Support Project in the state's tal Health Region III. Region III, in the h central part of the state, is a largely ranch and farm area of approxi- ly 150,000 persons, and the city of gs, with about 100,000 residents, is area's economic and health service er: The regional community mental th center, located here, was chosen ne CSP core service agency.

uring June, 1978, the center's after- clientele were screened to deter- e need for community support ram services. The screening device l was the "Georgia Definition" (see endix A), which consists of two check- of criteria of need for community sup- such as frequent hospitalization and of social supports. Clients meeting or more criteria on the first checklist three or more criteria on the second cklist were selected for enrollment in Community Support Program. Out of ftercare population of 550, about 260 ts, or 47%, met the Georgia criteria eed for the program services.

attempting to document whether or the program has been adequately emented, two things are necessary: a sure of CSS delivery and some sort of rol group of clients who are not par- ating in the program. To measure ery of services, a locally developed ument was used. For each of eight ice categories, each divided into ral finer subcategories of service, e managers were asked to estimate many units of service their clients received in the past month. The eight categories were crisis assistance, stance in applying for benefits, chosocial rehabilitation, mental/- ical health care, assistance to the munity, client rights and grievances, e management, and transportation. endix B contains a complete list of the ice categories and subcategories.

o construct a control group for the clients above, the aftercare clientele regional CMHC *not* served by CSP screened with the Georgia checklist. Those clients who met the criteria based upon their behavior and history as of June, 1978, were put into a control group of "CSP eligibles" for assessment purposes. Use of the Georgia checklist ensures that this group is comparable to the CSP clients in terms of need for CSP services. There may be geographical and center-related differences between the two groups in addition to the principal difference of program versus lack of program, of course.

Procedure

Random samples of twenty-one CSP clients and fourteen CSP eligibles were chosen to be assessed. During June, 1979 (one year after commencement of CSP services), the case managers of the two groups of clients were identified and asked to complete the service delivery instrument for each of their clients.

Two measures were derivable from the service delivery instrument; a measure of service quantity and a measure of service variety. Quantity of service can be measured by counting the number of units of service reported. However, this is a somewhat unsatisfactory measure due to the variety of unit types within each category: days, hours, trips, visits, etc. By simply counting number of units one is implicitly equating one hour of outpatient service to one day of residential service (for example), even though the former is obviously more service intensive than the latter. It was decided instead to measure service variety by counting, for each service category, the number of different types of service for which the client received at least one unit.

After the data were collected, the following information was recorded for each client: group membership (CSP client or CSP eligible), and number of different types of service delivered for each of the eight service categories. Analyses of variance were then performed on these eight service measures, and on the sum of the eight measures as well.

Results

The *F* ratios, significance levels, and means for each of the nine ANOVAs are reported in Table 1.

The CSP clients were found to have received a significantly greater variety of psychosocial rehabilitation and health care services than the CSP eligibles (using the conventional level of statistical significance). The average CSP client received 2.19 different types of psychosocial rehabilitation service, compared to .93 different types for the average CSP eligible. With regards to health care, the average CSP client received 1.66 different types of service, as opposed to .78 different types for the average CSP eligible. For the remaining six service categories, no significant differences between the two groups were found.

Analysis of the *total* number of different services received showed that the average CSP client received significantly more different types of community support service than the average CSP eligible. This indicates that the CSP clients are indeed receiving a greater array of services than similarly disabled clients not participating in the CSP program.

Table 1

Analyses of Variance on Measures of Service Variety

Service category	*Mean, number of different services 21 CSP clients*	*Mean, number of different services 14 CSP eligibles*	*F (1,33)*	*p*
crisis assistance	.29	29	.00	1.00
benefits assistance	.38	21	68	.42
psychosocial rehabilitation	2.19	.93	4.32	.046
health care	1.66	.78	7.96	.008
assistance to community	.29	.14	.47	.50
client rights	.06	08	.08	.77
case management	.66	.28	2.06	.16
transportation	.29	.07	1.38	.25
total	5.81	2.79	6.10	.005

Discussion

Before becoming concerned with demonstrating the *outcome* of a Community Support Project, it is necessary to show that the program is being successfully *implemented*. In Montana the following strategy was adopted: a group of clients at an agency not involved in CSP activities was screened with the same criteria used to determine client eligibility for the program in the core service agency. This group of "CSP eligibles" was used as a control group for a sample of CSP clients. The two groups were then compared on a measure of community support service delivery one year after program commencement. If the program is in fact being implemented adequately, the CSP clients should be receiving a greater variety of community support services than the CSP eligibles.

Analysis of the data showed that, overall, CSP clients were in fact receiving a greater variety of community support services than the CSP eligibles. When the individual service categories were examined, the CSP clients were found to be receiving a greater variety of psychosocial rehabilitation services and health care services than the CSP eligibles. Somewhat surprisingly, such key features of a community support program as benefits assistance, case management and client rights and grievances did not show similar differences between the two groups. The results therefore indicate that these areas need more concerted effort on the part of CSP staff.

Perhaps the major problem with this type of design is the fact that the treatment and control groups come from two different mental health agencies in two different geographical regions. Therefore, the differences observed may be due to agency/regional differences rather than to the fact that one agency has the program and other does not. To rule out this possibility, it would be necessary to collect data with the service delivery instrument from both groups both before and after program start-up. Unfortunately this data was not collected, and the format of the MIS systems at the two agencies does not permit retrospective gathering of the data.

Under the circumstances, a stronger research design for assessing program implementation would consist of time series observations of those aspects of implementation recoverable from agency records, thereby allowing both retrospective data collection and before-after comparisons. This strategy will be the focus of Montana's evaluation efforts during the coming contract year.

APPENDIX A

Criteria for Admission to Community Support Program.

To qualify for the CSP, an aftercare client must meet at least one criterion under section A, and at least three criteria under section B.

a *Mental Disability*

The severe or persistent emotional disorder has resulted in:

___ two or more hospital admissions with a 12-month period

___ a single episode of hospitalization since 1973 of at least one-year duration

___ patient has been followed with medication only for at least one year

___ patient has been enrolled in Day Care or has been receiving supportive living services for a six-month period

___ patient has been a high user of unscheduled contact with the mental health system for more than six months

b *Impaired Role Functioning in the Natural Environment*

In addition, because of the extent of their mental disability, these individuals typically:

___ are unemployed with markedly limited job skills and/or a poor work history

___ are employed in a sheltered setting

___ are unable to perform basic household management tasks without assistance

___ exhibit inappropriate social behavior which results in rejection by the community and requests for intervention by the mental health or judicial/legal system

___ are unable to procure appropriate public support services without assistance

___ require public financial assistance for out-of-hospital maintenance (SSI, general assistance, supportive living funds, etc.)

___ severely lack social support systems in the natural environment (no close friends, live alone, no group affiliations, highly transient)

___ are placed in a nursing home setting because of financial considerations and/or because a less restrictive suitable environment is not currently available

___ are non-compliant recipients of mental health services when a clear need for such is evident

APPENDIX B

Community Support Services Categories

II. DIRECT SERVICE CODE NUMBERS & DESCRIPTION

1.0 *Crisis Assistance*
- 1.1 Telephone Crisis Service
- 1.2 Face to face contact at provider facility
- 1.3 Telephone information and referral service
- 1.4 Face to face information and referral service
- 1.5 Visits to client's home
- 1.6 Short term hospitalization
- 1.7 Short term supportive living arrangement
- 1.8 Face to face contact someplace other than client's home or provider facility, e.g., hospital emergency room, police station, etc.
- 1.9 Other (specify) _____

2.0 *Assistance in Obtaining Benefits*
- 2.1 Counseling and training of client
- 2.2 Provision of written material to client
- 2.3 Active advocacy with mainstream agency or other key actor on client's behalf
- 2.4 Assessment of client's benefit status
- 2.5 Assist client in obtaining benefits. Go with them. Accompany them.
- 2.6 Other (specify) _____

3.0 *Rehabilitative and Supportive Services*
- 3.1 Evaluation of client's needs
- 3.2 Employment related activities
  - 3.21 Pre-vocational rehabilitation
  - 3.22 Vocational rehabilitation

3.23 Time-limited sheltered workshop
3.24 Non-time limited sheltered workshop
3.25 Transitional employment
3.26 Work training
3.27 Adult Education
3.28 Time limited special work placement
3.29 Non-time limited special work placement
3.291 Training in job seeking

.3 Activities to enhance living arrangements
3.31 Training in community living skills
3.32 Time-limited supportive living arrangement (e.g. normative community setting with 24 hours of live in staff)
3.33 Non-time limited supportive living arrangement (e.g. normative community setting with 24 hours of live-in staff)
3.34 Time-limited semi-independent living arrangement (e.g. cooperative self-help housing, limited with supportive and rehabilitative services)
3.35 Non-time-limited semi-independent living arrangement (e.g. cooperative self-help housing, limited with supportive and rehabilitative services)

3.4 Recreation and Socialization Activities
3.41 Time-limited planned daytime activities
3.42 Non-time-limited planned daytime activities
3.43 Time-limited planned evening activities
.3.44 Non-time-limited planned evening activities
3.45 Time-limited planned weekend and holiday activities
3.46 Non-time-limited planned weekend and holiday activities

3 5 Other (specify) _____

Medical and Mental Health Care

4.1 Medical Care
4.11 Physician Service
4.111 At provider facility
4.112 At client's home
4.113 At other site
4.12 Nursing Service
4.121 At provider facility
4.122 At client's home
4.123 At other site

4.2 Dental Care

4.3 Mental Health Care
4.31 Medication
4.32 Individual Treatment
4.321 At provider facility
4 322 At client's home
4.323 At other site
4.33 Group treatment
4.331 At provider facility
4.332 At other site

4.4 Other (specify) _____

5.0 *Assistance to Client Families and Community*
5.1 Telephone consultation to:
5.11 Client immediate family member
5.12 Client relatives
5.13 Landlord
5.14 Neighbors and friends
5.15 Employer
5.16 Police
5.17 Other (specify)_____

5.2 Face to face consultation to:
5.21 Immediate family
5.22 Relative
5.23 Landlord
5.24 Neighbors and friends
5.25 Employer
5 26 Police
5.3 Other (specify) _____

6.0 *Protection of client's rights*
6.1 Counseling and training of client in his/her rights
6.2 Provision of written material to client
6.3 Active advocacy with other agency in behalf of client
6.4 Assessment of client's situation
6.5 Other (specify) _____

7.0 *Case Management*
7.1 Phone contacts of primary staff worker/care manager with client
7.2 Face to face contacts of primary staff worker/care manager with client
7 3 Other (specify) _____

8.0 *Transportation Services*
8.1 Provider owned vehicle used for transport of clients
8.2 Provider subsidized use of public transportation
8.3 Provider subsidized use of private transportation
8.4 Other (specify) _____

The Public Cost of Treating the Chronically Mentally Ill in the Community

Results of a study conducted by:
JoAnn Bisogno, MSW;
Margery Braren, Ph.D.;
Robert Ingalls, Ph.D.;
Marlene Levin, MPA;
George Nash, Ph.D.;
Phyllis Scott, MSW;
Anthony Zuccarro, MSW.

For many years now, both New York State and the nation as a whole have had a policy of providing as much treatment and service as possible to the chronically mentally ill in community settings rather than in institutions. While the main impetus behind this deinstitutionalization policy has been the belief that the treatment provided in the community is of higher quality and more normalizing than treatment provided in institutions, there is also a widespread belief that community care is less costly to the taxpayers than is comparable institution-based care. However, to date, there is little information available either to support or refute this latter assumption.

While the cost per patient day in an institution can be readily determined, and the costs associated with specific com-

A Probability Model of a Residential Continuum

for the Chronically Mentally Ill

(Evaluation and the Health Professions, in press)

(Task 7, Sub-task B)

A Probability Model of a Residential Continuum for the Chronically Mentally Ill

David Drachman
Department of Institutions
Helena, Montana

A Probability Model of a Residential Continuum for the Chronically Mentally Ill

A key component of community support programs for the chronically mentally ill is the residential continuum. Rather than attempting to move a client directly from the hospital to an independent community setting, the client is first placed into a highly structured group home, and then, if he progresses satisfactorily, is moved into a more independent, but still supervised living situation. If further growth is shown by the client, he then is allowed to move out into the community. The goal is to establish a continuum of living situations, ranging from highly structured to nearly independent, which will ease the client's transition from hospital to community. Ideally this continuum will consist of a wide range of residences in terms of level of independence, so that the step from one level to the next will not be too large. The presence of several levels of independence also serves to mitigate the effects of a relapse by allowing the regressing client to move to a lower level living situation rather than going back to the hospital.

One of the tasks of Montana's Community Support Project has been to develop a residential continuum in the City of Billings, a regional trade center with a population of 100,000 in the south central part of the state. This particular continuum was designed to facilitate the transition of psychiatric patients from the state hospital (located in another part of the state) to independent or quasi-independent living in Billings. It consists of three types of residences: two twenty-four-hour group homes, which are staffed around the clock by mental health workers who closely supervise and direct client activities; a forty-hour group home, which is staffed for eight hours during the day, five days a week; and two cooperative apartments, the residents of which exercise a degree of self-govern-

ment over their own affairs. These latter homes are supervised only one hour per day during the week.

In order to obtain an understanding of how the residential continuum operates, and how well it operates, a method describing the movement of clients between the continuum's various components must be found. Such a model of client movements, once developed, can then be used to answer such questions as the following: 1) if the residential continuum is at full capacity, how many of the original residents will still be living there one year later? 2) how many new residents can be admitted to the continuum over the course of a year? 3) how efficiently is the continuum operating?

A group of probability models which are well-suited to answering these kinds of questions are those known as Markov processes (Stokey and Zeckhauser, 1978). A Markov process described the flow of persons or other entities between various states or conditions in terms of the probabilities of an entity moving from one state to another in a given period of time. In the present application, the entities are clients and the states are the various living situations described above. Assuming that it always can be determined what facility a client is in and that he can only be in one facility at a time, the probability that a client will transition to any given facility from any other (or the same) facility can be determined. These transition probabilities can be represented in matrix form as shown in Table 1 below.

- -

Insert Table -1- About Here

- -

In this hypothetical example, the numerical entries are interpreted as follows: the probability that an individual presently in the state hospital will be in the state hospital one year later is .30. The probability that this individual will be in the community one year later is also .30. The probability that an individual in the community will be in the community one year later is .50. The remaining entries are interpreted in the same way. It should be noted that the entries in each row must always add up to 1.0.

In order to compute transition probabilities from actual data, two mathematical assumptions must be made. First, it is assumed that the probability that an individual moves from one facility at time T to another facility at time T+1 depends only on his location at time T, and not on his whereabouts at earlier times T-1, T-2, etc. Markov processes which meet this assumption are called first-order Markov processes (Anderson & Goodman, 1957). Secondly, it is assumed that the transition probabilities hold for all time periods under consideration; that is, they do not change over time. Markov processes which meet this assumption are called stationary Markov processes (Zahl, 1955). The data to be presented shortly were modeled with a stationary, first-order Markov process.

METHOD

Attendance data were collected from records at the two twenty-four hour group homes, the forty-hour group home, and the two cooperative apartments for a seventeen-month period from January 1, 1978 to May 31, 1979. A total of eighty-seven individuals were found to have lived in these residences during that time. Next, attendance records from the state hospital and the inpatient unit were consulted to determine residence by any of the above eighty-seven clients during

the same time period. If a client was not found to be in any of the above five residences at a given point in time, he was assumed to be in the community, although it is possible that a few of these clients may have been in out-of-state facilities at such times.

Clients who resided at the state hospital or inpatient unit, but not in any part of the residential continuum during the seventeen months were excluded from the analyses. The focus of the present study was on the fates of the continuum residents only, rather than on all residents of all five facilities.

Location of each of the eighty-seven clients was recorded at the beginning of the seventeen months and at the end of twelve-week intervals thereafter. Therefore there were seven time-series observations for each of the eighty-seven clients. Transition probabilities for the twelve-week interval were calculated for each possible pair of locations as follows: the number of transitions from location X to location Y after twelve weeks elapsed were counted (over all clients) and divided by the number of transitions from location X to any location. The resulting number is the probability that a client in location X at a given point in time will be in location Y twelve weeks later. The six-by-six matrix of all such twelve-week transition probabilities was used as the basis for the further calculations.

RESULTS

The matrix of twelve-week transition probabilities is presented in Table 2.

Insert Table -2- About Here

With one exception, the largest probability in each row lies on the main diagonal; these are the probabilities of being in the same facility twelve weeks later. These large probabilities reflect the fact that a client is quite likely to remain in a given facility for more than twelve weeks. The one exception (logically as well as numerically) is the inpatient unit, where clients rarely stay more than a few days or weeks at a time.

Given that the data do indeed conform to the assumed stationary first-order Markov process, we can use the matrix of twelve-week transition probabilities to answer a variety of questions regarding the flow of clients among the five facilities and the communities. First, however, it is necessary to test the validity of the assumed model by measuring its goodness-of-fit to the actual data. The following notation will be adopted: $\underline{o}_1$ is the vector of observed numbers of clients in each of the six locations at the beginning of the seventeen-month period, and $\underline{o}_7$ is the vector of observed numbers of clients in each location at the end of the period (the seventh time-series observation). $\underline{P}$ is the six-by-six matrix of twelve-week transition probabilities (Table 2). In all cases the left-to-right and top-to-bottom order of locations will be state hospital, inpatient unit, 24-hour group home, 40-hour group home, cooperative apartment, community.

Markov theory allows us to obtain the transition probabilities for longer periods of time from the twelve-week transition matrix $\underline{P}$. In general, the transition matrix for a V x twelve-week matrix is simply $\underline{P}$ raised to the V power (Bartholomew, 1973)[1]. The twenty-four-week transition matrix is therefore $\underline{P}^2$ and the seventy-two-week (seventeen-month) matrix equals $\underline{P}^6$. This latter matrix is presented in Table 3.

Insert Table -3- About Here

$\underline{P}^6$ is interpreted in exactly the same manner as $\underline{P}$. For example, the probability that a client in the state hospital at the beginning of the seventeen-month period will be in the state hospital at the end of the period is .172, and the probability that he will be in the community at the end of the period is .489.

From the data it was found that $\underline{o}_1 = \overline{/}\ 1 \quad 0 \quad 15 \quad 8 \quad 10 \quad 53\ \overline{/}$. If the model is an accurate description of client movements, then the transition probabilities of $\underline{P}^6$, when applied to the initial frequencies $\underline{o}_1$, should yield expected frequencies which agree closely with the final frequencies $\underline{o}_7$. For example, how many of the eighty-seven clients should be found in the community at the end of the period? The answer is found by element-wise multiplying $\underline{o}_1$ by the last (community) column of $\underline{P}^6$: (1 x .4894) + (0 x .5323) + (15 x .5010) + (8 x .4447) + (10 x .4762 + (53 x .6073) = 48.51. Therefore, if the model is accurate, we should expect to find approximately forty-nine clients in the community at the end of the period. The above operation can be executed for all six locations by performing the matrix multiplication: $\underline{o}_1 \times \underline{P}^6 = \underline{e}_7 = \overline{/}\ 4.17 \quad 3.09 \quad 15.51 \quad 7.20 \quad 8.52 \quad 48.51\ \overline{/}$ where $\underline{e}_7$ equals the estimated number of clients in each location at the end of the seventeen-month period. The actual end-of-period frequencies were found to be $\overline{/}5 \quad 1 \quad 15 \quad 7 \quad 8 \quad 51\ \overline{/}$ A chi-square test comparing $\underline{e}_7$ with $\underline{o}_7$ showed very close agreement between the expected and observed values (chi-square with 5 d.f. = 1.76, $\underline{p} < .90$). Therefore, it appears that a first-order, stationary Markov model adequately fits the data.

Having established that the model is a reasonable one, we can utilize it to answer the questions raised in the introductory section. If the residential continuum is at full capacity (thirty-three beds), how many of these residents will still be in the continuum one year from now? To answer this question we need to find the transition probabilities for one year. A close approximation to the one-year matrix of transition probability is found by calculating $\underline{P}^4$ (this gives the probabilities for a forty-eight week period). If we treated the residential continuum as a single facility, $\underline{P}^4$ would look as shown in Table 4.

Insert Table -4- About Here

From this matrix we can expect that 53.26% of the original thirty-three residents, or approximately eighteen, will be residing in the continuum one year later. Some of these eighteen may, of course, have spent some time outside of the continuum during the one-year period. The number of clients who will be found in the continuum at the end of all four twelve-week periods is obtained by multiplying 33 x (.5326) = 2.66, or roughly three clients. Therefore, although we expect to find over half (18 of 33) of the original residents still there one year later, we expect to find only 9% (3 of 33) as residents at the end of all four twelve-week periods. This indicates quite a bit of mobility on the part of the continuum's population.

Using similar logic, we expect to find 3.44% of the continuum's original residents, or approximately one, at the state hospital one year later; 2.89%,

or about one resident, at the inpatient unit one year later; and 40.41%, or approximately 13, in the community one year later.

How many new residents can be admitted to the residential continuum during the course of a year? Recall that at the beginning of the period of observation, there were five clients in the state hospital, one client in the inpatient unit, thirty in the residential continuum, and fifty-one in the community. If we treat the residential facilities as one facility, a four x four matrix of transition probabilities $\underline{P}$ is obtained which can be multiplied by the beginning period frequencies $\overline{/1 \quad 0 \quad 33 \quad 53/}$ to determine movement into and out of the continuum. Multiplying $\overline{/1 \quad 0 \quad 33 \quad 53/} \times \underline{P}$ yields the expected frequencies $\overline{/1.79 \quad 2.96 \quad 31.72 \quad 50.53/}$. Comparing the 31.72 to the original 33 residents allows one to conclude that one residential bed will have opened up at the end of the first twelve-week period. The expected frequencies, so obtained, can then be multiplied by $\underline{P}$, obtaining a set of expected frequencies for the end of the second period, $\overline{/2.65 \quad 3.06 \quad 31.73 \quad 49.56/}$. At the end of the second period, the continuum capacity has not changed (31.72 vs. 31.73). Repeating this procedure yields expected frequencies of $\overline{/3.26 \quad 3.08 \quad 31.76 \quad 48.89/}$ for the end of the third period and $\overline{/3.70 \quad 3.10 \quad 31.77 \quad 48.42/}$ for the end of the fourth period. These results lead to the conclusion that movement out of the residences is matched almost exactly by movement into the continuum over a year's time. It therefore seems reasonable to expect that few new beds will be opening up in the future. The expected frequencies also reveal a small increase in the state hospital and inpatient populations at the expense of the community population.

It is also possible to develop indices of overall continuum performance from the transition probabilities. Miley et al (1978) developed an index of mental

health system performance by combining transition probabilities with "restraint" values associated with transitioning between each pair of states. These restraint values were based upon hours of supervision required for clients in each of four "states" or programs, ranging from inpatient to community. The resulting index is hard to evaluate because it is difficult to specify a maximum and a minimum feasible value for the index.

A simpler approach which avoids this problem was therefore adopted. Based upon the transition probabilities, the number of clients progressing along the continuum or maintaining at their present level over the course of one year was divided by the total number of clients. This proportion must range between a minimum of zero and a maximum of one. Using the forty-eight week matrix of Table 4, the index yields a value of .937; that is, 93.7% of the clients can be expected to remain in the continuum or progress to the community after forty-eight weeks. A performance index can also be calculated for each component of the continuum. The twenty-four-hour group homes have a performance index of 93.6%, the forty-hour group homes have an index of 82.6%, and the co-operative apartments have an index of 82.3%.

DISCUSSION

The residential continuum is regarded by many to be a basic component of viable community support systems for the chronically mentally ill. However, little data has been provided describing how these continuums actually function. Such a description requires that a method be found for depicting and summarizing the flow of clients between the various facilities inside and outside the continuum. One such method is to represent the flow with a

Markov process, which conceptualizes client movements in terms of probabilities of movement from one facility to another.

Some data from a residential continuum in Billings, Montana, were analyzed with a first-order, stationary Markov model. Transition probabilities were calculated from the data, and the goodness-of-fit of the model was tested and found to be adequate.

Several implications were then drawn from the model. First, the transition probabilities were used to determine how many continuum clients will be residing in the continuum one year later, and how many clients will be residing in the continuum at the end of each observation period. The results suggested a very mobile group of clients who nevertheless tend to return to the continuum, rather than relapse to the hospital, after long periods. The model was also used to determine how many new residents could be admitted to the continuum over a year's time; it was found that only one new resident could be. The model revealed that new openings in the continuum were almost precisely filled by clients moving from the state hospital, inpatient unit or community.

Finally, a set of indices were developed in an attempt to assess the efficiency of the residential continuum. It was found that, after forty-eight weeks, 92.7% of the continuum's clients could be expected to remain in the continuum (although some may have regressed within the continuum) or progress to the community. In an overall sense, then, the residential continuum appears to be functioning as intended.

While useful in describing and predicting functioning of the continuum, there are limitations to probability models such as the one explicated here. Transition probabilities do not cast any light on the why of client movements. They also cannot easily be brought to bear on the participation of continuum clients in several programs simultaneously: many of the clients participate in partial hospitalization and other programs while they reside in residential facilities. Membership of clients in two or more states simultaneously cannot be easily dealt with by a Markov model. In spite of these difficulties, Markov models can be useful devices for obtaining an overview of client flows, for assessing the adequacy of client flows, and f for planning the placement of future clients.

NOTE

1. It should be noted that the process of raising P to a higher power involves a series of matrix multiplications, not the raising of each matrix element to a higher power.

REFERENCES

Anderson, T.W. and L.A. Goodman (1957) "Statistical inference about Markov Chains: Annals of Mathematical Statistics 28; 89-110.

Bartholomew, D.J. (1973) Stochastic Models for Social Processes. London: John Wiley.

Miley, A.D., B.L. Lively and R.D. McDonald (1978) "An index of mental health system performance." Evaluation Quarterly 2(1): 119-126.

Stokey, E., and R. Zeckhauser (1978) A Primer for Policy Analysis. New York: W.W. Norton.

Zahl, S. (1955) "A Markov process model for followup studies." Human Biology 27: 90-120.

Table 1

One-Year Matrix of Hypothetical Transition Probabilities

		TO				
		state hospital	inpatient unit	24-hour group home	40-hour group home	cooperative apartment	communi
FROM	state hospital	.30	.00	.20	.10	.10	.30
	inpatient unit	.50	.10	.10	.10	.10	.10
	24-hour group home	.10	.20	.50	.10	.00	.10
	40-hour group home	.10	.10	.20	.40	.10	.10
	cooperative apartment	.10	.20	.10	.10	.30	.20
	community	.10	.10	.00	.10	.20	.50

Table 2

Matrix of Twelve-Week Transition Probabilities

	TO					
	state Hospital	inpatient unit	24-hour group home	40-hour group home	cooperative apartment	community
state hospital	.7143	.0714	.0714	.0000	.0000	.1429
inpatient unit	.1177	.0588	.2941	.1177	.0000	.4118
24-hour group home	.0109	.0109	.7283	.0652	.0000	.1848
40-hour group home	.0213	.0213	.0213	.7660	.0426	.1277
cooperative apartment	.0000	.0172	.0172	.0172	.7931	.1552
community	.0136	.0442	.0578	.0034	.0272	.8537

Table 3

Matrix of Seventy-two-week Transition Probabilities
(Twelve-week Matrix Raised to the Sixth Power)

	TO					
FROM	state hospital	inpatient unit	24-hour group home	40-hour group home	cooperative apartment	commu
state hospital	.1723	.0424	.2002	.0585	.0372	.48
inpatient unit	.0678	.0359	.2032	.1010	.0600	.53
24-hour group home	.0454	.0323	.2539	.1167	.0507	.50
40-hour group home	.0548	.0330	.1256	.2373	.1046	.44
cooperative apartment	.0282	.0313	.1180	.0592	.2870	.47
community	.0489	.0374	.1758	.0548	.0758	.60

Table 4

Matrix of Forty-Eight Week Transition Probabilities

	TO			
	state hospital	inpatient unit	residential continuum	community
state hospital	.2887	.0490	.2460	.4163
inpatient unit	.0794	.0357	.3751	.5098
residential continuum	.0344	.0289	.5326	.4041
community	.0423	.0391	.2595	.6591

C. Contextual Factors Affecting the Project

The climate of fiscal conservatism which provails in much of the country exists in Montana as well. At the state, county, and municipal levels, legislators, commissioners and other officials are giving frugal responses to the funding requests of human service agencies. These decision-makers, under pressure from the public to hold down taxes, are demanding that human service agencies budget for a no-growth, "hold-the-line" level of services. These demands are particularly threatening to a project like CSP, whose very point and purpose is to augment services for the chronically mentally ill, not merely to sustain present services.

Montana's CSP staff have attempted to counteract this problem by pointing out, at every opportunity that presents itself, that the expense of enhanced community-based services is more than redressed by the savings earned by not having to hospitalize as frequently. This argument, compelling as it may be, is always in danger of being ignored by funding decision-makers anxious to halt spending growth in any way possible. Community support services, being the most expensive that the CMHCs offer, are especially vulnerable to being cut during periods of funding cut-backs. For example, one center spends 40% of its 1.5 million dollar budget on its 300 CSP clients, and half of this amount is spent solely on its 35 group home clients (approximately 1% of its total yearly caseload.) The temptation to divert this money into serving a much larger number of outpatient clients is a strong one. Montana's CSP staff, in promoting community-based services for the chronically mentally ill, must continue to be extremely vigilent in combatting these tendencies.

Two other problems related to funding should be mentioned: 1) county commissioners and other state legislators are reluctant, due to the pressures discussed above,

to accept short-term federal funds if the funders expect the fundees to maintain the program with state or local monies when the federal funds terminate; 2) a cut back in funding from one source tends to induce other sources to cut back their funds. For example, the Cascade County government reduced its funding to the Great Falls Mental Health Center upon learning that the center had received a reduced amount of money from state and federal sources. The reasoning behind such reductions is that "we are not going to pick up a larger share of the bill- if others see fit to cut back, we will too".

The tightening of funding in recent years has also fostered another unfortunate tendency - competition between the state hospital and the CMHCs and among the centers themselves for funding - tends to promote jealously among these agencies and interferes with the kinds of interagency communication and cooperation needed to build an optimal CSS in Montana. Since there is never enough state funding to meet all the requests of these six agencies, they tend to blame the Department of Institutions for failing to lobby strongly enough with the legislature and the Governor's Office for larger levels of state funding.

The problems related to securing funding for CSS development discussed above are not insurmountable, but they clearly point to the need for Montana's CSP staff to be extremely cognizant of them in promoting CSS development.

Providing culturally relevant services for Native Americans poses problems not encountered to the same degree with any other underserved group. This is due to the extremely high drop-out rate of young Native Americans, which makes it very difficult to find suitably qualified paraprofessional, let alone professional counselors. Although the cultural sensitivity of non-Indian mental health professionals can be increased to enhance their effectiveness, the quickest way to achieve rapport with Native American clients is to provide Native American counselors. Some definite strides in this direction have been made, but progress

will be slow as long as such a large proportion of Montana's Native Americans fail to complete high school.

A factor which would potentially impair the effectiveness of the CSP staffs, both at the state and regional level, is the smallness of these staffs. Both at the Mental Health Division and the five centers, the small size of the work force requires CSP workers to perform some other duties of a non-CSP nature, in order that the division/centers may continue to function and fulfill all their obligations. In a sense this is a very fortuitous situation, for it requires the CSP workers to maintain a global familiarity with their agency's functioning which improves their ability to manipulate the system to the advantage of community-based programs. However, there is always a danger that these non-CSP duties may divert too much of the CSP staffer's time from accomplishing vital tasks.

Attempting to evaluate Montana's CSP efforts has raised problems by creating extra demands on the staff for data collection. Unfortunately, the typical MIS is not capable of providing enough detailed information on the important aspects of community support services. As a result, special questionnaires must be designed to be completed by therapists, which adds to their already extensive MIS reporting and record-keeping burden. The evaluator has had to take special care to design questionnaires and interview formats so that staff burden will be minimal, in order to ensure staff cooperation.

D. Administrative Information

1) In January, 1978, Montana's CSP started and within six months all three state CSP positions were filled. These positions remain unchanged today and the resumes of these staff have been sent in previously in '80 Technical

Proposal.

State Coordinator, Philip Powers
Starting date: 1/1/78
% of time on CSP is 100%

State Program Evaluator, David Drachman
Starting date: 5/1/78
% of time on CSP is 100%

Warm Springs State Hospital Liaison, Sandra Mattioli
Starting date: 6/1/78
% of time on CSP is 100%

Within this same 6 months period the following 3 positions were filled by the South Central Montana Mental Health Center, the model demonstration agency and have remained the same. Resumes were sent in previously in '79 Technical Proposal.

Regional Coordinator, John Noteboom
Starting date: 2/1/78
% of time on CSP is 100%

Sub-contract Center Employees

Social Worker, Joan Smith
Starting date: 2/1/78
% of time on CSP is 100%

Secretary, Elrene Dorn
Starting date: 2/1/78
% of time on CSP is 30%

On July 1, 1979, Eastern Montana Mental Health Center became a core service agency for Montana's Community Support Project and the following staff (Resumes in Technical Proposal of '80) are utilized via the subcontract:

Mental Health Worker, Neysa Battleson
Starting date 7/1/79
% of time on CSP is 50%

Sub-contract Center Employees

Mental Health Worker, Nena Saunders
Starting date: 7/1/79
% of time on CSP is 50%

Mental Health Worker, Dorothy Diede
Starting date: 7/1/79
% of time on CSP is 50%

Sub-contract Consultant

Mental Health Worker, Reservation Consultant, John Paul Flying
Starting date: 7/1/79
% of time on CSP is 50%

Non-Sub-contract Center Employee	Regional Coordinator, James Petersen Starting date: 7/1/79 % of time on CSP is 40%

On March 1, 1980, Northcentral Montana Mental Health Center became a core service agency and the following staff are utilized via the sub-contract (see enclosure for resumes)

Non-Sub-contract Center Employee	Regional Coordinator, Ken Kleven Starting date: 3/1/80 % of time on CSP is 40%
	Mental Health Worker, John Struss Starting date: 3/1/80 % of time on CSP is 100%
Sub-Contract Center Employees	Mental Health Worker, Yvonne Hess Starting date: 3/1/80 % of time on CSP is 100%
	Social Worker, Frank Toner Starting date: 3/1/80 % of time on CSP is 100%

On September 1, 1980, Western Montana Mental Health Center is to become a core service agency and the following staff will be utilized via the subcontract:

(See enclosure for Job Descriptions)

Non-Contract Center Employee	Regional Coordinator, David Washburn Starting date: 9/1/80 % of time on CSP is 40%
Sub Contract Center Employees	Mental Health Worker, Starting date: 9/15/80 % of time on CSP is 100%
	Mental Health Worker, Starting date: 9/15/80 % of time on CSP is 100%

APPENDIX I

RESUMES

APR 2 0 1980

STATE OF MONTANA
APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER

FOR STATE USE ONLY

8776 8

INSTRUCTIONS: Applications that are not filled out completely cannot be considered. If a question does not apply to you write in letters "NA". Completed applications will not be acknowledged until job opportunities occur. Applications are retained for six months, except those for Merit System positions which are retained for thirty months. To be considered for employment after six months, please submit a new application.

1. Name	Last: X STRUSS	First: VICTOR	Middle: JOHN
2. Address	Street: 1321 7TH ST SOUTH #23		
	City: GREAT FALLS	State: MONT.	Zip: 59405
3. Phone Number	NONE	4. Social Security No.	516-72-8649
5. Date of Birth	7/26/55	6. Present Age	24
7. Marital Status	Single	8. Number of Dependents (excluding self)	0
9. [X] Male [ ] Female		10. Height: 5'11"	Weight: 160

EMPLOYMENT INTERESTS

11. Type of Work Desired
A: MENTAL HEALTH WORKER I
B:
C:

12.

Will you accept	Yes	No	Will you accept:	Yes	No
Permanent Work?	X		Temporary Work?		X
Full-time Work?	X		Part-time Work?		X
Employment anywhere in the State?					X

If "no" state preference: GREAT FALLS, MONT

13. Date Available: MAY 1, 1980

14. Minimum Monthly Salary: $700

15. Date of separation if considering short-term employment: N/A

16. Dates and name of State agency by which previously employed: MONTANA STATE EMPLOYMENT 8/19/79

	Yes	No
17. Are you a citizen of the United States?	X	
17a. If you are not a citizen, have you filed a Declaration of Intent?		
18. Do you have a valid Montana driver's license? Operators	X	
Chauffeurs		X
19. Have you ever been convicted of a felony? If "yes" What? Where?		X
20. Have you any physical defects, chronic disease or other disability? If "yes," explain:		X
21. Are any members of your immediate household employees of the State of Montana? If "yes," identify by name, relationship and agency:		X

RECEIVED
APR 24 1980
MERIT SYSTEM BUREAU

22. Do you claim veteran's preference? If "yes" and applying for a Merit System position, please request and complete supplemental form.

23. Give the name, address and phone number of three persons, other than present or prior employers or relatives, who have knowledge of your character, experience and ability.

A: VIRGIE SANDS 715 3RD AVE NW #6 — 454-1787
B: 912 1 AVE N.W (AL GINGER) — 452-6757
C: ROBERT ROBE / MALSTROM AIR FORCE BASE / NO PHONE)

24. If you are applying for a Merit System position, please complete this section. Read the announcements relating to the examination and make sure you have complied with all the requirements. You will be notified of the time and place of examination(s).

•Examination center preferred:	STATE USE ONLY A	R
POSITIONS APPLIED FOR		
1. MENTAL HEALTH WORKER I 490	4-24-80	
2.		
3.		
4.		
5.		
6.		
7.		
8.		

MERIT SYSTEM

EDUCATION

Mark (x) last year successfully completed ▶

LEVEL	NAME AND LOCATION (CITY/STATE)	MONTH/YR FROM	MONTH/YR TO	MAJOR AND MINOR COURSE OF STUDY	QTR/HR EARNED	DEGREE CERTIFICATE
Last High School Attended	Sunburst High, Mont	9/72	6/73			G.E.D
COLLEGE OR UNIVERSITY						
Business or Vocational						
Other						

SPECIAL QUALIF.

26 Describe licenses and registries, skills with machines, publications authored, professional or scientific societies of which you are a member, typing and/or shorthand speed, honors, awards or fellowships, foreign languages understood or spoken, specialized training, civic activities, etc.

Tyring I,

TEN YEAR EMPLOYMENT RECORD (List Most Recent First)

27 Begin with your present or last job and list your employments in reverse order for the last 10 years. Including military service. Indicate positions were full or part time. Use additional sheets if necessary.

•Do you object to an inquiry of your last employer regarding your character and qualifications? (x) ▶ Yes

A
Employer's Name and Address: Mental Health Center
Immediate Supervisor: Andree DeLigouri
Dates: Start 8/79 End — (Still wo)
Duties (include job titles, responsibilities and supervisory experience): Driver - Giving clients rides To and from For appointments, my Job is making sure They get Their on Time. I also run mail route he cen
Reason for Leaving ▶ Position open for mental Health Worker I

B
Employer's Name and Address: Plummers Enterpises 1111 14 south
Immediate Supervisor: William Plummer
Dates: Start 1-78 End 12-79
Duties (include job titles, responsibilities and supervisory experience): Maintainance supervisor on twelf apt Buildings, Repair work. broken wi electrical work. Plumbing. Lawn work & Painting
Reason for Leaving ▶ Layed off

C
Employer's Name and Address: Circle K Great Falls, Mont
Immediate Supervisor: E-Day Stelks
Dates: Start 8-76 End 12-78
Duties (include job titles, responsibilities and supervisory experience): Assistant Mananger, Cashier, Taking over For Mananger - doin Books stocking, ~~Fast~~ running store on mananger Days off.
Reason for Leaving ▶

D
Employer's Name and Address: Circle K Havre, Mont. 10041
Immediate Supervisor: Nancy - Forget
Dates: Start 8-74 End 12-74
Duties (include job titles, responsibilities and supervisory experience): Cashier. Doing Books, stocking, Janatorial work
Reason for Leaving ▶ Temperary work

E
Employer's Name and Address: DM Nolon Company Alhambra, Calif
Immediate Supervisor: Jack Swartz
Dates: Start 2-74 End 7-74
Duties (include job titles, responsibilities and supervisory experience): Spray. sparkle ceilings, Repair work patch up walls, carpentry Painting
Reason for Leaving ▶ Lack off Pay

F
Employer's Name and Address: Comanche Drilling CO. Cutbank
Immediate Supervisor: Robert Lee
Dates: Start 7/73 End 12/73
Duties (include job titles, responsibilities and supervisory experience): Rough Neck Drilling For oil Duties include sample catcher
Reason for Leaving ▶ I was sick for Two weeks & was replaced

I hereby certify that this application is true and complete to the best of my knowledge. I am aware that any falsification or misrepresentation may disqualify me from any employment with the State of Montana.

Victor Stluis
Applicant's Signature

4-2

STATE OF MONTANA
APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER

FOR STATE USE ONLY

INSTRUCTIONS: Applications that are not filled out completely cannot be considered. If a question does not apply to you write in letters "NA". Completed applications will not be acknowledged until job opportunities occur. Applications are retained for six months, except those for Merit System positions which are retained for thirty months. To be considered for employment after six months, please submit a new application. Mailed applications are to be addressed to your local employment office.

	Last	First	Middle
1. Name	TONER	DONALD	HUGH
2. Address	Street: 420 50TH. STREET SOUTH		
	City: GREAT FALLS	State: MT	Zip: 59405
3. Phone Number	727-3387	4. Social Security No.: 136 32 5413	
5. Date of Birth	30 SEP 1930	6. Present Age: 48	
7. Marital Status	MARRIED	8. Number of Dependents (excluding self): 5	
9.	[X] Male [ ] Female	10. Height: 5'-8"	Weight: 160

EMPLOYMENT INTERESTS

11. Type of Work Desired: A; B; C

12.

Will you accept	Yes	No	Will you accept:	Yes	No
Permanent Work?			Temporary Work?		
Full-time Work?			Part-time Work?		
Employment anywhere in the State?					
If "no" state preference					

13. Date Available:

14. Minimum Monthly Salary:

15. Date of separation if considering short-term employment:

16. Dates and name of State agency by which previously employed:

	Yes	No
17. Are you a citizen of the United States?	X	
17a. If you are not a citizen have you filed a Declaration of Intent?		
18. Do you have a valid Montana driver's license? Operators / Chauffeurs	X	
19. Have you ever been convicted of felony? If "yes" What? Where?		X
20. Have you any physical defects, chronic disease or other disability? If "yes," explain		X
21. Are any members of your immediate household employees of the State of Montana? If "yes," identify by name, relationship and agency		X
22. Do you claim veteran's preference? (If "yes" and applying for a Merit System position, please request and complete supplemental form.)	X	

23. Give the name, address and phone number of three persons, other than present or prior employers or relatives who have knowledge of your character, experience and ability.

A

B

C

24. If you are applying for a Merit System position, please complete this section. Read the announcements relating to the examination and make sure you have complied with all the requirements. You will be notified of the time and place of examination(s).

•Examination center preferred:

POSITIONS APPLIED FOR	STATE USE ONLY ▼ A	R
1.		
2.		
3.		
4.		
5.		
6.		
7.		

EDUCATION

25. Mark (x) last year successfully completed ▶ | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |

LEVEL	NAME AND LOCATION (CITY/STATE)	MONTH/YR FROM	MONTH/YR TO	MAJOR AND MINOR COURSE OF STUDY	QTR/HR EARNED	DEGREE OR CERTIFICATE
Last High School Attended						
COLLEGE OR UNIVERSITY						
Business or Vocational						
Other						

SPECIAL QUALIF.

26. Describe: licenses and registries; skills with machines, publications authored, professional or scientific societies of which you are a member; typing and/or shorthand speed; honors, awards or fellowships, foreign languages understood or spoken, specialized training; civic activities, etc

TEN YEAR EMPLOYMENT RECORD (List Most Recent First)

27. Begin with your present or last job and list your employments in reverse order for the last 10 years. Including military service. Indicate if positions were full or part time. Use additional sheets if necessary

•Do you object to an inquiry of your last employer regarding your character and qualifications? (x) ▶ Yes | N

A

Employer's Name and Address | Immediate Supervisor | Dates: Start / End | Salary

Duties (Include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

B

Employer's Name and Address | Immediate Supervisor | Dates: Start / End | Salary

Duties (Include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

C

Employer's Name and Address | Immediate Supervisor | Dates: Start / End | Salary

Duties (Include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

D

Employer's Name and Address | Immediate Supervisor | Dates: Start / End | Salary

Duties (Include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

E

Employer's Name and Address | Immediate Supervisor | Dates: Start / End | Salary

Duties (Include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

F

Employer's Name and Address | Immediate Supervisor | Dates: Start / End | Salary

Duties (Include job titles, responsibilities and supervisory experience)

Reason for Leaving ▶

I hereby certify that this application is true and complete to the best of my knowledge. I am aware that any falsification or misrepresentation may disqualify me from any employment with the State of Montana

STATE OF MONTANA
APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY EMPLOYER

OR STATE USE ONLY

INSTRUCTIONS: Applications that are not filled out completely cannot be considered. If a question does not apply to you write in letters "NA". Completed applications will not be acknowledged until job opportunities occur. Applications are retained for six months, except those for Merit System positions which are retained for thirty months. If you are considered for employment after six months please submit a new application. Mailed applications are to be addressed to your local employment office.

PERSONAL DATA

	Last	First	Middle
1. Name	TONER	DONALD	HUGH
2. Address (Street)	420 50TH STREET SOUTH		
City	GREAT FALLS	State MT	Zip 59405
Phone Number	727-3387	4. Social Security No.	136 32 5413
5. Date of Birth	30 SEP 1930	6. Present Age	48
7. Marital Status	MARRIED	8. Number of Dependents (excluding self)	5
9. [X] Male [ ] Female		10. Height 5'.8"	Weight 160

EMPLOYMENT INTERESTS

11. Type of Work Desired: A; B; C

12.

Will you accept:	Yes	No	Will you accept:	Yes	No
Permanent Work?			Temporary Work?		
Full-time Work?			Part-time Work?		
Employment anywhere in the State?					
If "no" state preference					

13. Date available
14. Minimum Monthly Salary
15. Date of separation if considering short-term employment
16. Dates and name of State agency by which previously employed

GENERAL

	Yes	No
17. Are you a citizen of the United States?	X	
17a. If you are not a citizen, have you filed Declaration of Intention papers?		
18. Do you have a valid Montana Driver's License? Operator's / Chauffeur's	X	
19. Have you ever been convicted of a felony? If "yes," What? Where?		X
20. Have you any physical defects (hearing, eyesight, etc.) that limit you? If "yes," explain		X
21. Are any members of your immediate family employed by the State of Montana? If "yes," identify by name, relationship and agency		X
22. Do you claim veteran's preference? (If "yes" and applying for a Merit System position, please request and complete supplemental form.)	X	

PERSONAL REFERENCES

23. Give the name, address and phone number of three persons, other than present or prior employers or relatives, who have knowledge of your character, experience and ability.

A

B

C

MERIT SYSTEM APPLICANTS

24. If you are applying for a Merit System position, please complete this section. Read the announcements relating to the examination and make sure you have complied with all the requirements. You will be notified of the time and place of examination(s).

•Examination center preferred. POSITIONS APPLIED FOR	▼ STATE USE ONLY ▼ A	B
1.		
2.		
3.		
4.		
5.		
6.		

Donald Hugh Toner
Telephone: (406) 727-3587

4528-B Hickory Street
Great Falls Montana 59405

CAREER OBJECTIVES:

Employment in a challenging position in the field of Human Resources which would offer an opportunity to utilize proven abilities and education.

EDUCATION:

Obtained High School equivalency certificate.

Graduated from University of Nebraska at Omaha with a Bachelor's Degree. Major in Social Science, Minor in Psychology.

Enrolled in Teacher's Education and completed the following courses:
Dynamics of Adjusted Behavior
Abnormal Psychology
Introduction to The Exceptional Child
Introduction to Mental Retardation
Methods of Teaching The Mentally Retarded (emphasis on behavior modification)
Curriculum Development for The Mentally Retarded.
Curriculum Development for The Secondary School.

Student taught at CMR High School. Performed individual instruction with students who were experiencing difficulties with their studies. Student taught History and Psychology.

Graduated from Ball State University Muncie Indiana with a Master's Degree. Major in Counseling Psychology.

Completed two practicum courses in counseling psychology.

Donald Hugh Toner

MILITARY EXPERIENCE:

Progressive supervisor with over 20 years experience which required the ability to effectively interact with individuals and groups of different ages and professional competencies. Supervised on a continuing basis approximately 15 people.

Advanced from Basic Airman to Senior Master Sergeant. Performed duties in an environment that consisted of daily contact with those under my supervision.

Performed duties as a trainer, teaching new airmen mechanical skills.

Supervised and counseled individuals on improving their lifestyles.

Inspected living quarters occupied by those under my supervision. Made improvements in living conditions.

Provided vocational and educational counseling.

Conducted placement examinations and assigned individuals to tasks.

Documented counselings and recorded personnel improvements and progress.

Communicated, orally and in writing, effectively.

Acted as liaison officer in times of dispute. Settled complaints in a timely and courteous manner.

Performed and documented surveys on housing suitability.

Performed family counseling.

Donald Hugh Toner

CIVILIAN EXPERIENCE:

Probation and Parole Officer.
Duties consisted of the following: signing up new cases, investigating: placements, discharges, work furlough plans and requests under the Interstate Compact Agreement, contacting local agencies and arranging programs for clients, obtaining estimates for the payment of restitution, obtaining and examining police, FBI, Sheriff's and traffic records, counseling individuals and families, interpreting school and mental health records, effectively handling a case load of approximately fifty (50) persons, conducting pre-sentence and social background investigations, testifying before the court and effectively communicating with county attorneys and defense attorneys.

My clients included individuals who were emotionally disturbed and some who were mentally retarded.

PERSONAL DATA

Height 5'8"
Weight 160 Pounds
Marital Status Married, 3 children
Born September 30, 1930 Everett, Wash.

SPECIAL SKILLS

Certified Teacher
Authorized School Psychologist

HOBBIES

Little League Manager
Racquet Ball Player
Fishing, Camping, Hiking and Reading

GEOGRAPHIC PREFERENCE

1. Great Falls
2. Montana

Donald Hugh Toner

REFERENCES:

Patrick Ryan
Distric Probation Parole Officer II
600 Central Plaza, Suite # 18
Great Falls MT 59403 Ph. 727-6061

Jerome J. Skiba
Distric Probation Parole Officer III
600 Central Plaza, Suite # 18
Great Falls MT 59403 Ph. 727-6061

David Wyman
4707-B Joshua Street
Great Falls MT 59405 Ph. 761-6139

Dave Callies
600 10th Av. S.W.
Great Falls MT 59404 Ph. 452-8718

Lee Gray Ph.D
Skyline Elementary School
3300 3 N.W.
Great Falls MT 59401 Ph. 791-2266

STATE OF MONTANA

APPLICATION FOR EMPLOYMENT

AN EQUAL OPPORTUNITY EMPLOYER

FOR STATE USE ONLY

INSTRUCTIONS: Applications that are not typed or printed in ink will not be accepted. If questions do not apply to you write in letters N/A. Applications will not be retained for six months except those [illegible] upon request.

Mental Health Worker

Hess Yvonne Sharon

1601 5th Ave So

Gt Falls Mt 59405

761-4273 516-72-9036

7/12/57 Age 21

Single

X Female

5' 6½" 165

11/27/78

Will you accept Temporary Work? Yes X

Part time Work? No X

Gt Falls

14 Minimum Monthly Salary 727.00

If hiring short term NA

16 Name of State agency by which previously employed Vista, 11-77 to 11-78 YEC 6-77 to 9-77

	Yes	No
[illegible] the United States?	X	
[illegible]		
Operators	X	
Chauffeurs	X	
[illegible]		X
[illegible]		X
[illegible]		X
[illegible] supplement[al] form		X

[illegible] Bonnie Fayler, 1101 6th Ave NW, 452-8745 WORK (761-2104)

[illegible] Margaret Brown, 812 11th St So 453-1586

[illegible] Mrs. Williamson, Dani's Beauty College, (454-3453) WORK

[illegible] for a Merit System position please complete [illegible] relating to the examination [illegible] have complied with all the requirements [illegible] examination(s).

Mental Health worker

▼ STATE USE ONLY ▼

A	B

EDUCATION

GT Falls High School 9-72 12-74 2 yrs

Beauty College 6-75 5-77

SPECIAL SKILLS

Indian Language (Cree), Attended Indian Ed for Gen Ch
Member of Indian Assoc meetings. Training in Waitress +
attended Beauty College Volunteer work at New Directio
Judo classes at YMCA, Sports at Heisey

TEN YEAR EMPLOYMENT RECORD (List Most Recent First)

A Mental Health Center, (Dist.) 11/26/77 25
P.O. Box 2717, Great Falls, MT. 59403 Nancy Kramm, MSW 11/26/7
Work Supervisor in Vocational Work
Charge of Groom Program, Help organize + participate in Field Trips, Sports
Craft groups + Jewelry Therapy groups, + Childminder for Clients, Keep Books
for one of Work Units + did general office work. During Un
▶ Term of Visit ended

B YEC Opptunies Inc. Summer of
Robert Bradford 72, 73, 74
Waitress, Cleaning, yard work, Dish washing, Mental Health
mopping, Sweeping, windows, clean tables, Kichen Helper
▶ Term ended

C Duties (include job titles, responsibilities and salary)
Reason for leaving ▶

D Employer's Name and Address
Duties (include job titles, responsibilities and salary)
▶

E Name and Address
Duties (include job titles, responsibilities and salary)
▶

F Name and Address
Duties (include job titles, responsibilities and salary)
Reason for Leaving ▶

I hereby certify that this application is true and complete to the best of my knowledge. I am aware that any falsification of the information on this application may be grounds for not employing me or for dismissal after employment.

Applicant's Signature 11/1

NORTHCENTRAL MONTANA COMMUNITY MENTAL HEALTH CENTER

AUG 22 1980

No: 21

Updated: 11/76

JOB DESCRIPTION

Center Title:	Statewide Classification:
HEAD OF ALTERNATIVE SERVICES	SOCIAL SERVICES DIRECTOR Grade: 17
Program:	**Location:**
ALTERNATIVE SERVICES	GREAT FALLS CENTER

Job Description: In a regional mental health center, assumes responsibility for the development, implementation and coordination of Alternative Services in specified geographical areas.

Responsible To: Assistant Director

Specific Responsibilities:

1. Implements instructions of Assistant Director.
2. Supervises and directs all members of Alternative Services Team.
3. Plans and implements Alternative Services Program in Cascade County consisting of:
   A. Precare Services.
   B. Day Treatment (partial hospitalization) Services, both acute and long term services.
   C. Transitional and long term placement services throughout the region in conjunction with county heads of services.
   D. Aftercare services.
4. Participates in the development of an annual budget for Alternative Services.
5. Participates in the delivery of direct evaluation and treatment services to clients and their families.
6. Establishes a program of case consultation and, where appropriate, program consultation for individuals, agencies, and institutions dealing with the target population of the Alternative Services Team. Coordinates programs with the Regional Director of Consultation and Education.
7. Establishes educational programs to inform the public of (a) needs of the target population of Alternative Services and (b) the nature of the services and how to obtain them. To the extent possible, portions of this program should be in the form of films, slides, video, and/or audio tapes for widespread use in the catchment area.
8. Participates in hiring and evaluation of Alternative Services Division employees.
9. Provides staff with appropriate inservice training.
10. Maintains complete clinical records on all Alternative Service Clients.
11. Participates in the evaluation of quality of clinical services delivered by Alternative Services staff.
12. Participates in inservice training as directed by immediate supervisor.

Minimum Qualifications:

1. Knowledges and Abilities: Considerable knowledge of the theories, principles and practices of psychiatric social work; modern administrative supervisory techniques; resident facilities and administration. Ability to supervise and evaluate work of subordinates; plan and develop long-range programs; communicate effectively both orally and in writing.
2. Education and Experience: Graduation from a college or university with a Master's Degree in Psychiatric Social Work. Five years of progressively responsible administrative or supervisory experience in a psychiatric social work field.

OR

Any equivalent combination of education and experience.

KENNETH BERGER KLEVEN

Personal Data

Born:	May 12, 1942, Salt Lake City, Utah .
Age:	32
Height:	5'9"
Weight:	165
Social Security:	528-52-5858
Health:	Excellent
Mailing Address:	1916 East 3060 South, S.L.C. Ut. 84106
Telephone:	466-8251

Education

Graduated with Masters in Social Work from University of Utah 1967-69.

Graduated with B.A. in Sociology (minor in Language and Psychology) from University of Utah 1964-67.

Attended Brigham Young University for one semester 1961.

Graduated from Olympus High School in Salt Lake City, 1957-60.

Employment History

Private Practice - October 1, 1974 to Present (6-16-75)
Marriage, family and individual counseling.

Utah State Division of Mental Health, 554 S. 300 E., Salt Lake
Supervisor: Wilfred Higashi, Ph.D., Director.
September 1971 to October 1, 1974
Mental Health Specialist, to establish a comprehensive mental health center in Northern Utah, supervise and direct clinical services and provide direct services.

California State Dept. of Social Work, Ukiah, California.
Supervisor: Walter Ihl
June 1969 to September 1971
Psychiatric Social Worker, counseling with children, adolescents, married couples and families. Supervising and consulting with state licensed family care homes for emotionally disturbed and mentally ill.

New Hope Private School, P.O. Box 543, Boonville, California.
Supervisor: James G. Dean
October 1970 to September 1971.
Social Work Consultant, consulting with school staff as to individual boys' problems, program development and inservice training.

Anderson Valley School District, Boonville California.
Superintendent Mel Baker
September 1970 to September 1971
Social Work Consultant, evaluating children for placement into educationally handicapped classes with continued consultation with school teachers as to each student's progress.

L.D.S. Unified Social Services, 37555 Dusterberry, Fremont, Calif.
Supervisor: Lynn H. Crockett, September 1970 to September 1971.
Lamanite Assistant, providing consultation to foster parents with Indian children in their home and direct services to the children.

L.D.S. Santa Rosa Stake, 1780 Yulupa Ave., Santa Rosa, Calif.
Bishop Don McCallum
August 1970 to September 1971
Psychiatric Social Worker, counseling with members of the LDS Church with personal problems, marriage counseling and family therapy.

Ukiah Unified School District, Ukiah, California.
Supervisor: none
September 1970 to May 1971
Advisor to youth group serving mentally retarded persons.

University Hospital, University of Utah, Salt Lake City, Utah
Supervisor: Mrs. Apostle
March 1967 to May 1969
Case Aide in Emergency Room. Handled all social, emotional and personal problems. Notified relatives as to injuries and deaths. Worked closely with the doctors concerning all traumatic patients.

Department of Public Assistance, State of Washington
Supervisor: Rose Flarity
June 1968 to September 1968
Caseworker II, general caseload of 250 people on skid row. Did all eligibility work plus social services as needed.

Salt Lake City Police Dept. Metropolitan Hall of Justice, Salt Lake City, Utah.
Supervisor: Captain Calvin Whitehead
September 1966 to January 1967
Clerk-typist. Handled complaints and general office police work.

Christiansen Brothers Construction Company, Salt Lake City, Ut.
Supervisor: Rolf Christiansen
April 1964 to October 1964
Laborer

Served a mission for the L.D.S. Church in Norway
August 1961 to February 1964

Graduate Fieldwork Experience

American Fork Training School for the Retarded
September 1968 to June 1969
Counselor

Central Utah Mental Health Clinic
September 1967 to June 1968
Counselor

Davis County School District
September 1967 to June 1968
School Social Worker

Professional Organizations

National Association of Social Work, Licensed Social Worker State Board of Education, Academy of Certified Social Workers, Certified Social Worker State of Utah.

Community Service

President of Northern Utah Branch of NASW Chapter 1972-73 and 1973-74. Chairman of the Board Brigham City Listening Post 1973. Member of the Board of Directors Box Elder County Mental Health Association and Board Member Brigham City Drug Abuse Council 1972.

References

Wilfred Higashi, Ph.D., Director, State Division of Mental Health
554 S. 300 E., Salt Lake City, Utah 84111

Dr. Thomas S. Fox, Director, Northern Utah Mental Health Clinic
160 North Main, Logan, Utah 84321

Mrs. Carolle Bell, A.C.S.W., Mental Health, County Courthouse
Brigham City, Utah 84302

Richard Kimber, Pupil Personnel Director, Box Elder County
School District, County Courthouse, Brigham City, Utah 84302